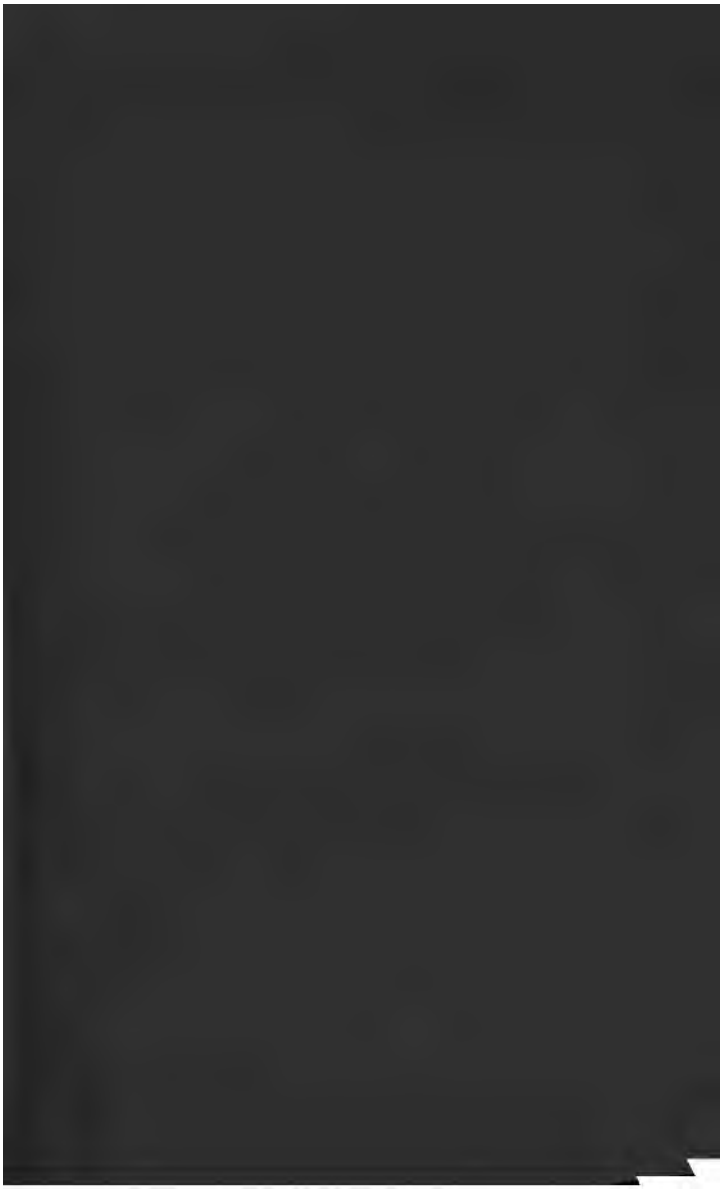
AIDS TO DIAGNOSIS

PART III.

WHAT TO SEE

FOTHERGILL



AIDS

TO

DIAGNOSIS.

PART III.—WHAT TO ASK.

SPECIALLY DESIGNED FOR STUDENTS AND JUNIOR PRACTITIONERS.

BY

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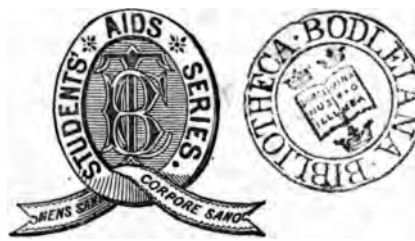
'He that questioneth much shall learn much.'



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PREFACE.

WHEN the student first sees patients by himself, he is often at a loss what questions to put, and how to put them. He has read his text-book honestly—can write a description of a disease very fairly—but when brought face to face with it scarcely knows how to proceed so as to get at one feature after another *seriatim*. He is specially troubled with the interrogation of a patient as to what he feels; yet a subjective sensation is often the clue to the correct interpretation of the symptoms presented. This little work is an attempt to help him in this matter. Imperfect it must necessarily be; but if it helps him on his way to educate himself, it is not quite worthless.

AIDS TO DIAGNOSIS.

PART III.—WHAT TO ASK.

INTRODUCTION.

THE questions which a medical man puts to his patient are the measure of his knowledge to that patient and that patient's friends. They cannot judge of his skill in making a physical examination; though they can have, and do have, their opinion as to whether he is taking pains, or making the examination in a mere perfunctory manner; but they can estimate the questions he puts as to their fitness. It is like watching an archer: we cannot tell what amount of skill he may actually possess; but we can note whether the arrows fall on the target, or fly wide of the mark. So with the medical man and his questions. If these are well put on the target, that is, elicit an affirmative answer, they demonstrate his acquaintance with the case before him. If question after question brings forth merely a negative answer, it is obvious to all the doctor is floundering about; if question after question is followed by a ready response, and the patient experiences what is asked, it is equally clear that the doctor is familiar with the nature of the case, and knows what he is about. In one the confidence of the patient is acquired; in the other case it is withheld—not unnaturally.

The student in the wards hears the notes of a case read; he hears the physician, or surgeon, put sundry questions; but he rarely knows intelligently why

particular question is asked, because he does not recognise its bearing. Physical signs are comparatively simple matters, involving pains and industry for their acquirement, and are of immense value, say, in the recognition of cancerous nodules on the liver, or a mitral obstructive murmur. But beyond the matter of pains or the want of it, the patient's friends can tell nothing of the value of the examination. Nor, again, except in obvious gross disease, are they of much service to the bulk of practitioners. Indeed, often they only lisp, and do not speak. Percussion tells of dulness of one apex. The respiration is diminished, or jerking. The case may be recent or old, the presence of moist rales or their absence alone is of any service in indicating its probable duration. Here the student, yes, and his seniors, too, for that matter, are brought up sharply. How is the case to be determined? Only by careful examination; or cross-examination, as the case may be. You may look carefully to see if there is any retraction below the clavicle. Good move that! There is some; and the hollow so formed does give valuable information. But the difficulty is still far from solved. Now comes in interrogation. What are the associations of developing phthisis? The questions put will tell several things. They will tell the questioner much; the observant friends of the patient—taking their notes about the doctor—a great deal more. The first question should be, "Have you lost flesh lately?" But the patient should be looked at keenly before asking this, to see if the skin looks loose, or the clothes hang slack; if the clothes are well filled, such question is a mistake—perhaps a blunder. The next, "Do you sweat at nights?" If so, the case is clearing up. Look at the tongue; if red, irritable, or denuded of epithelium, it is safe to ask, "Have you any diarrhœa?" The answer is, "Yes." You may then ask, "Is it mostly after food?" An affirmative answer is terribly suggestive. The patient will often save any necessity for asking the last question by volunteering, "No; but I often am sick after eating." By this time it is getting significantly clear that the case is recent, and the outlook is ominous. But if the answers are all nega-

tive, then probably the injury is of old standing and comparatively devoid of significance. But the cautious student will be guided as to how he puts the question—whether for an affirmative or negative answer, by what his eye tells him; just as he would look at a mutilated hand to see if the cicatrices are red and recent looking, or white and old, before he ask about any injury to it. He must put his questions as Opie, the painter, mixed his colours—"with brains." If he was the student I could like to see, he would keep his eyes open, and very open, while he approached the matter by asking the patient, "What do you complain of?" A story will come out, perhaps to the point, more often a rambling confused statement needing much sifting. But it is not well to start the sifting process right away, but to defer it. Keeping what has been said in mind, as furnishing clues to questions and inquiries to be made afterwards, proceed to ask, "Is your father alive?" "No." "What did he die of?" The patient does not know. Perhaps, after a while, he says, "Oh, he died of bronchitis!" This is indicative of reserve: so follow up, "Was he ill long?" "Yes; six months." Now he may have had bronchitis, but it is all Lombard Street to a Tangerine orange that he died of pulmonary phthisis. Or you are told he is alive, or was killed by an accident. Next proceed, "Is your mother alive?" Note the answer. If you can elicit a family history of pulmonary phthisis, or its absence, you have learnt much of real value about the patient; and that will teach you much about the probable progress of the case; and this, in turn, will guide your prognosis, and direct your therapeutic measures. If a woman, ask if married. If so, "How many children have you had? At what intervals?" If she says none, or one, or two, ask if she has had any abortions, vulgarly spoken of as "slips." If she has, it is as bad, or even worse for the health, than childbearing. If you find reasons for thinking the lung mischief recent, with such a history the case is a serious one; the family history being very useful in determining your opinion of the gravity of a case.

Now, if the young student would ask his questions in

this order, he would probably do two things; (1) he would learn much that is of the greatest value; and (2) he would have so put his questions that it would be clear he knows what he is about. "Judge of a man by his questions rather than his answers," said Voltaire.

Or a man, a workman comes to you, saying that "he has been refused from a provident club, because his heart is diseased;" a very common occurrence. You look at him. If he speaks out strongly, and declares that he ails nothing, never felt ill in his life, and at the same time his breathing is calm and slow, probably there is a mistake somewhere. If his words are not corroborated by such semeia, and his breathing is rapid, and still more there is the suggestive "venous flush" on his face, probably there is disease, though he may think himself all right. You strip him, look at him, feel over the heart, percuss, and then put on your stethoscope. You hear a loud murmur at the apex, carried forward towards the ensiform cartilage. Without going into detail, you have good reason to suspect mitral stenosis. Well, how are you going to propose to find out whether this is what may rightfully be termed "disease" or not? Because it will not do to go away, or perhaps, to speak more accurately, to be carried away, with the idea that because there is a murmur, therefore there is necessarily disease; it is only very probable that there is disease. You continue your examination: there is no accentuation about the second sound at the pulmonary orifice, nor any indications of enlargement of the right heart. You then inquire, "Can you run?" "Oh yes!" says the man, "quite well!" "You are not out of breath soon?" "Oh no!" he replies. "It does not give you palpitation?" "What is that?" he asks. (It is pretty clear he does not have palpitation, when he has to ask what it is!) "Can you do your work?" "Yes." "What are you?" "A mason." "Can work all day!" "Yes." "Can you lift a big stone easily?" "Oh yes! I am a famous fellow for a lift!" Well, now, it is very nearly certain that this man's murmur is due to some congenital peculiarity at his mitral ostium, or some slight roughening of the free edges of the valves. But it is the interrogatory and the

answers which must tell what the case probably is. It will not do either in the patient's interests or your own, if you will believe me, youthful reader, to stand helplessly before a cardiac murmur and only dread the worst.

Now these are two illustrations of what the line of inquiry should be; first in a case sadly frequent, the second only comparatively rare. It is not merely that a mistake is always a matter of regret. If you do not believe me, just wait, and you will see for yourself. But the prospects of a case of early apex-mischief with a bad family history, and of old-standing consolidation as static as the scar of a bypast ulcer, are about as widely different as the poles are asunder. In each case you have before you either something very serious, and which will demonstrate its seriousness before long, and illustrate the accuracy of your grave prognosis only too probably; or something on which you can talk cheerfully, with every prospect of the patient not only living a good while, but also willing to testify to your acumen and knowledge.

Or you are called to a woman obviously far advanced in pregnancy who believes herself to be commencing in labour. How are you to tell whether or not the pains be "false"? My midwifery is very rusty. I will acknowledge that; but I believe the configuration of the os is in dispute; so is the hardening of the uterus at the "pain." Sir James Simpson taught the only guide is the character of the pains; and it often stood me in good stead, and kept me on the rails when otherwise I might have slipped. "True" pains come on at regular intervals; "false" pains come on in a cluster, and then take themselves off. Say it is the country, about nightfall, three or four miles away. For your own comfort and reputation the diagnosis now becomes important. Are you to stay all night, or go home again? If you make a mistake, too, it will be marked against you. Possibly you will feel as if you wished you had attended to what the obstetric lecturer was saying that day when you carved your initials so neatly, or read that trashy novel. But regret at this stage won't do much for you; and the question of whether you are going to make a fool of yourself, or not, is imminent. Even that little pocket

manual of midwifery would have helped you, but it is at home at the bottom of a lot of books in a chest. So there is nothing for it but taking a step forward. You ask her, "How far are you gone?" The usual time is given. The uterus is nearly at the ensiform cartilage. Now for it! If you have carried away from your teacher useful knowledge you will ask about the pains. "Did they come on suddenly?" An affirmative answer. "Did they come on rapidly?" "Yes, quite fast!" "And left off suddenly?" "Yes!" You can tell the man outside holding your horse to bring him up, and ride home to your bed. To have the horse stabled for the night, to sit about that cottage till morning; and then ride home leaving the woman *in statu quo*, and when the neighbours ask you if it is a boy or a girl (what can you say?), to mumble out an unsatisfactory answer, is not to cut a brilliant figure; nor yet to establish a firm reputation among the proletariat of that neighbourhood.

"What to ask" is then a matter that may come sharply home to you some day. If the pains are regular, at fairly rhythmic intervals, then you must use your discretion, be the same more or less, as to whether you will stay, or risk going home to be sent for later on. To tell you how to decide this is beyond my knowledge now; whatever I once might have been able to say on the matter. Each case requires its own answer.

CHAPTER I.

THE OUT-PATIENT.

THIS term is used here to designate also the equivalent of the "out-patient" of a hospital: viz., the club-patient who comes to the surgery, or the provident dispensary; or the patient who is well enough to call upon his medical attendant, instead of having to be visited.

While the eye is scanning the form of the patient, it is well to first inquire, "What do you complain of?" The answer will, if intelligently given, tell of the prominent symptom. Too frequently the answer is the name of the malady under which the patient suffers, or thinks she suffers; and some patients think they are very clever in having found out the name of their ailment, and that they so spare the doctor some trouble. It then becomes necessary to say, "I don't want a name; I want to know what you complain of?" Say the patient answers, "I have got a pain in my stomach, or my inside, or, maybe, my chest." It is well then to say, "Please put your hand upon the seat of the pain!" This will give you some definite idea of its locality. Suppose the patient puts his hand upon the abdomen at the navel, you will have valid reasons for believing the intestinal canal to be involved. Your next question will be—"Have you any diarrhœa?" "No," says the patient, "I am constipated;" or, in rural districts, "I am bound." You then say, "Are you generally constipated?" The answer will tell you whether the bowels are usually loaded or not. It is well then to say, "Have you taken any medicine to open your bowels?" This is a question of importance; as when an aperient medicine is taken in insufficient dose it starts up a good deal of peristaltic activity, but with-

out "operating." If, then, the answer is, "Yes, I took some pills last night," or, "some salts this morning," you will be informed that another and more effective dose of aperient medicine is indicated. If the answer is a negative one, then ask, "What have you been eating?" Often it will turn out the patient has been eating cold vegetables, or cucumber; or drinking sour milk, or old ale, or cider. If the pain be referred to the navel, you will suspect intussusception, or incarceration, or hernia, inguinal in man, or femoral in woman, or perhaps at the obturator foramen. If your suspicions run in this direction, ask, "Have you been sick?" Often the answer is, "Oh yes, very!" Always ask, "What was the vomited matter like?" You will often elicit, "Oh, I did not vomit: I was only sick!" Insist upon knowing if any actual vomiting took place. If the patient says, "It smelt like a motion!" you must look out for a block in the bowels somewhere. If the patient is noted to be compressing the bowels, it is very safe to ask, "Is the pain relieved by pressing on it?" If an affirmative answer be given, colic is pretty certain. If the pain is over the gall-bladder there is probably a gall-stone; if lower down, in the groin, it is probably a calculus in the ureter; if so, it is well to say, "Have you a pain in the testicle on that side?"—*i.e.* if the patient is an adult male. Then, "Is it drawn up?" If so, the diagnosis is pretty clear. Now, if the young practitioner puts his questions systematically, it tells that he knows what he is about. Further, it directs his physical examination in the right quarter for finding something. But he must not expect to be able to do this by merely knowing the array of symptoms of a disease as given in Prof. W. Charteris's little book, or even the completer work of Dr. Fred. Roberts. He must think for himself why certain maladies should give certain symptoms. This, I am afraid, he thinks very hard upon him; it gives so much more to get up. Well, now, that is natural enough. When a man is preparing for an examination, and has a great deal to get up—and further, when he knows that much to be got up is of small use to him, as, for instance, the relations of the common iliac, which he will never tie

—or, to be very safe, he is one hundred times more likely to be struck dead by lightning than be called upon to tie the common iliac—so he is suspicious of all demand upon him, unless its bearing on practice is quite obvious.

Now, my youthful reader, I do not want you to regard me as your enemy, or as an exacting taskmaster, but rather as an elder brother who speaks to you from what he has himself had to pass through. If you think why a long breath gives pain in pleurisy, you will at once know that when the pleuræ (or either pleura, for that matter), are inflamed, the surface is dry, and the friction of a long breath produces pain. Now, familiarity with this simple fact will often stand you in good stead in practice—put you on your guard in a case you might otherwise feel inclined to regard as pleurodynia. Or, what is common enough—so common indeed as to be discreditable to the profession—a woman tells you, "I have had inflammation in my side." Now, pleurisy is not by any means a common malady among women. You ask, "How do you know?" She answers, "Oh, the doctor told me so!" It is soon apparent that the trouble is intercostal neuralgia of the sixth or seventh nerve, and that the opinion of the medical man was given without due consideration. When you have discovered the error, don't parade your discovery! As a body the medical profession have lost more by the ready fault-finding of each other, in the rivalry of practice, than by all else put together. Clergymen and ministers never allow "the cloth" to be spoken of lightly; nor do "men of law" permit legal matters to be discussed flippantly. Yet nothing is more common than to find people—often ladies who should know better—asking doctors, almost immediately after being introduced, if they do not think such and such an opinion given by some other medical man, is wrong or improper. Your vanity is naturally flattered, and without first making quite sure that what is given as the opinion of the doctor was what he actually said, accurate and ungarbled—or, perhaps, even asking yourself whether your knowledge of the subject is full enough to entitle you to entertain

an opinion on it—you may rap out a crude answer without realising how much error as well as mischief you are propagating. If, on the other hand, you went into the subject carefully, cross-examined the questioner strictly but politely, you would probably achieve several desirable things. (1) You would save a medical brother from an unjust suspicion of want of knowledge; (2) you would show that medical matters are not subjects for flippant talk; (3) you would put a curb on a thoughtless wagging tongue, or, possibly, a mischief-maker; and (4) you would furnish a valid reason for being held to be a prudent young man. Now I think this much more desirable than "to show off" your knowledge at a brother's expense; rousing him to retaliation if what you say comes to his ears, as like enough it will. For many persons have some sort of impression haunting them that medical men are better kept at variance, and the more they are held "by the ears," the better it is for the laity; a very stupid and improper impression. So remember the honour of the profession of which you are a member, or an aspirant, and don't let a well-clad dame trot you out for her amusement; you have not secured her for a patient by so doing—mind that—nor gone the right way to secure her confidence either. Mind that, too!

Well, to return to the pain in the side. Women suffer much from "a pain under their heart"—often come to the doctor with the impression that the heart is "diseased." You find it possessing the truly neuralgic characteristics, according to Anstie. (1) It is one-sided; (2) it is not a steady pain, but gusty in character; (3) it is worse when the system is low; and (4) it is improved by tonics. Well, this last does not help you at the time, though worthy of being thought about as a guide in treatment. Now, you will find further, in well marked cases, tender spots along the course of the nerve—one the spot of pain complained of; so just pop your finger-end upon it, and the patient will start, and probably enter a sharp protest against your action; another at the middle of the outer edge of the scapula, and a third at the outlet of the posterior rootlet from the spinal cord. If you can pop a finger on each, she recognises

you know what you are after. Commonly, only the spot under the heart is markedly sensitive. These tender spots are known as "the spots of Valleix."

Or the patient complains of "pain in the back." If betwixt the shoulders it is dyspeptic; if lumbar, it is probably myalgic; if sacral, it is commonly uterine. Ask her to put her hand upon the seat of the pain. If betwixt the shoulders, ask, "Have you pain after food?" This will probably carry you along the symptoms of indigestion—too lengthy a matter to be entered upon here. If over the loins, ask, "Is it worse when you move?" and "Is it relieved when you lie down?" If each answer is in the affirmative, you recognise that the pain is myalgic, or muscular; and take your steps accordingly. If it is not so affected, look to the kidneys or the spinal column. If she places her hand over the sacrum, then ask, "Have you any bearing down?" "Have you pain when your bowels move?" Both of which probably she experiences. Then note if there be the tenderness in the groin, especially the left, by pressing your thumb over the left ovary. If the face puts on a look of suffering and nausea, you know you have to deal with a tender ovary—a very common occurrence indeed. If you will refer to page 99 of my "Aids to Rational Therapeutics," you will find the kind of case described. You can then ask after nausea, vertical headache, depression of spirits; if the answers are affirmative, you can proceed to ask, "Have you any difficulty in holding your water?"—a question which will impress the patient with your knowledge; if you are a very smart young man, and can put implicit trust in your self-possession, you may further ask, "Do you experience any heat, or dryness, and itching in your seat, or back passage, extending into the person?" Often she will answer, "Yes," in some surprise at the extent of your information. If all this be done successfully, you are entitled to regard yourself as an excellent practitioner in the egg, or rather in your chicken-feathers, and a youth your father ought to be proud of; and if he is a doctor, he will probably think so too; and perhaps trust you to call and ask after that young lady at the vicarage, who has had a cold, and in

whom you feel a very keen interest. Your progenitor may even throw out a hint—"If she is quite well, you may stay and play one game of lawn-tennis." And then you will feel rewarded for your acuteness, or that you are on the road to being rewarded; while your reputation will move upwards, you may depend upon it.

CHAPTER II.

THE IN-PATIENT.

THIS is meant to include the patient who has to be seen at home in bed, and who therefore is, or is supposed to be, seriously ill. It is when the friends of a patient are gravely alarmed that they scrutinise the conduct of the medical attendant most closely; and, if a young man and a stranger to them, perhaps even hostilely. So remember this when entering the house, and, still more, the sick-room. If you don't feel quite cool, try to look so. (There is a species of the *genus homo*, not quite unknown among the aspirants to medicine, who do not require this advice; the suggestion to "don a little modesty" would be more appropriate for them.) You are the object of watchful attention, so carry yourself accordingly.

Now, it is impossible, in the space at command, to do more than take one or two typical cases. The first we will suppose an old man in bed in a cottage. You note that he is propped up. If you see him breathing rapidly, or laboriously, it will tell you that in all probability he cannot lie horizontally, or, at least, is not comfortable so. Your first question will be, "Why are you in bed? Are you too ill to get up?" The answer is, "I am so short of breath!" or words to that effect; often, "I'm asthmatical"—asthma being a word in common use for dyspnœa in all its forms. You now know there is embarrassed respiration, but no more. Your next question will be, "Does it come on at times, or are you short of breath always?" "I am always short of breath; but I am worse at times than others!" Now this is not strictly grammatical; but you need not correct the old

man—he would not profit by it. "When do the attacks come on?" you will ask. "Oh, at nights, worst." "Do you wake up with them often?" "Yes; they often wake me." By this time you will probably begin to discern that there is embarrassment of the right ventricle. It is well at this point to feel the pulse; and to compare the ratio of it and the respiration as directed in "Semeiology," page 49. You at the same time listen acutely, and you will probably hear bronchial rales, so you ask, "Do you raise much phlegm?" "Oh yes, a sight!" This will tell you of free bronchial flow, or, "Very little; but it is very hard to get up!"—you now recognise that there is chronic bronchitis with emphysema; only you must make a careful examination physically to be certain about it. Interrogation is not intended to take the place of physical examination, but to guide and direct it. It may be well, at this point, to make some general inquiries. Lead off, then, with, "How do you sleep?" "Oh, very middling; the cough won't let me sleep!" or, "I sleep fairly, if a fit of asthma does not come on!" (The answer here will guide you as to the use of a night-pill of narcotic nature.) "Can you take any food?" should be the next question; and the answer will indicate the dietary to be advised—a very important matter, you will find. "Oh, I can only take a little brandy and water, or some beef-tea; and then the cough often brings it up!" (This patient is decidedly very seriously ill), or, "I can drink some milk, and eat a bit!" indicating that the nutrition is not failing. It is well to follow up with, "Are your bowels open regularly?" The answer is often, "No; I get very little through me!" Here bear in mind that the food does not give large motions; and also that old country people, not of the rank of gentle-folks, are careless about their bowels; so don't evince any surprise, but just make a note for your prescription. It is well to ask, "Are you always constipated, or not?" (The answer will tell you whether a laxative pill will meet the emergency or not.) Then ask, "Do you make much water?" (In some cases of old renal mischief they pass a good deal of water; in heart-disease, or chronic bronchitis, only a little.) "No;

very little indeed!" (Probably at this point one of the bystanders will throw in, "That is what is making us anxious, doctor!") Now ask for the chamber-utensil; and don't turn your nose up as if you had never looked into one before! See if the urine be clear and high-coloured; or there, also, be a deposit of lithates. If there be the latter, it is no use pushing the albuminoid elements of the dietary too far. Now, if you are a reflective youth, you will put this question, "Do you pass as much water as you used to do, or not?" The answer, "Oh no; not nearly as much," will tell you of a failing right ventricle. (It would be well on the first opportunity to read pp. 56-58 of "Semeiology" with reference to this matter.) "The water has been very short for a long time, doctor," will probably tell of old chest mischief. Then ask to see the legs—"Now let us look at the legs," is a familiar way of putting it. Having inspected the legs, and gleaned what information they can tell, you can proceed to examine the patient. You will probably find chronic bronchitis, with emphysema, and an enlarged right heart; with or without some mitral disease. Such is a case you will meet with very commonly in practice, and it is well to show familiarity with it; for these old invalids are "used to doctors," and are often very quick in noting how they go about their examination. Then the questions for a phthisical patient run on the same lines, except the urine.

Now a word or two about the attacks of nocturnal dyspnœa, which are common in both instances. The cause of inspiration is the presence of venous blood charged with carbonic acid, in the respiratory centre in the medulla; in deep sleep, in disease of the respiratory organs, sometimes the breathing falls so low that the blood is surcharged with carbonic acid gas; then, when a certain point is reached the centre is roused up to violent respiratory efforts—an attack of dyspnœa; after the blood is so freed from the excess of carbonic acid, the breathing quiets down, and the patient falls asleep readily. But when the right ventricle is over-distended the dyspnœa is not so readily relieved, and the attack continues some time. Now if you are sufficiently "well-

up" to fully realise this distinction, it is well to revert to the difficulty of breathing and ask about its duration—"Oh, it is soon over, and I drop off again!" is an answer that will relieve you. On the other hand, "I have a long fight to get my breath again!" will tell of a graver condition, where the right ventricle is involved. If the patient be far advanced in phthisis this is a common history. The patient falls into a deep sleep in the morning (four to seven usually), and then a profuse perspiration sets in; if some difficulty of breathing comes and keeps him awake, the terrible night-sweat is usually escaped. Knowing this, put your inquiries accordingly. "Do you fall asleep and have a bad sweat?" or "If you are kept awake the sweats don't come on?" It is as important to be clear about the night-sweats in phthisis as about the urine in a case of chronic bronchitis. Keep your head clear; and neither be in a hurry nor get flustered. In the case of the patient with chronic bronchitis, and emphysema with right side enlargement, it would be well to give the first and third prescription of p. 79, with ten minims of tincture of digitalis; and to diet him according to the directions given at p. 107 of the "Aids to Rational Therapeutics."

Now it will be well to take a more acute case—say a young woman who has been taken ill quickly, and who is in bed with what is suspected to be enteric fever. Here it is necessary to be clear about the diagnosis for many reasons, the treatment being of less importance than the general management of the case. You see her lying in bed looking nicely; nothing speaks of much amiss; the breathing is a little accelerated, so you lead off cautiously, feeling your way. "Why are you in bed?" you ask. "Because I don't feel well enough to get up," is the response. "Why! are you in pain?" said as if expecting a negative answer. "No; but I feel so weak." You remember muscular prostration is one of the symptoms of all fevers. "How long have you felt so weak?" you then ask. "Oh, I have felt as if my legs would sink under me for two or three days; and yesterday I was obliged to come to bed." Then follow up—"Have you had any shivering fits, as if cold water was running down

your back?" "Yes, I had, but they are gone." Then say, "Put out your tongue." It is coated. "Have you lost your appetite?" follows. "Yes; I can't look at food," is the answer. "How did you sleep last night?" Probably she may say "I don't know," and look at some one in an inquiring manner. Noting the direction of her gaze, you ask the woman, or girl, "Did you sleep with her?" "Yes," is the reply. "Was she restless?" "Yes; she was very uneasy." At this point it is well to take the temperature. While this is being done, you may make some general inquiries. Was the patient a strong girl? generally healthy? ever been complaining before?—keeping your eye on the possibility of some head mischief lurking. The temperature may not be high, but it is high enough to tell you that the case is not one of general debility, merely. Feel the pulse; it also is quickened. Your ideas will be taking shape by this time. Now examine the abdomen: you find it swollen, and tender, especially in the right iliac fossa over the ilio cœcal valve. A light pressure may produce some gurgling. Look out for the little rose-coloured spots; which are pathognomic when found, but which often are absent in private patients. Now ask to see the motion. It is brought. It is pea-soup like in colour, and its smell is offensive. See if there is any undigested curd of milk in it. If there is, make a quiet note thereof.

There is no moral doubt now about the case being one of typhoid fever. So you order the motions to be disinfected with carbolic acid, or carbolic powder, or chloride of lime; but not Condy's fluid (the last may be sprinkled over the floor of the room with advantage)—to be at once buried, or put down the water closet, if in a town; except the one to be kept for you to see, and you look at it, partly to familiarise your eye, and your nose too, for that matter, with a typhoid stool; partly to look out for milk-curd, or blood.

As to the progress of the case, watch it, read up enteric fever in Roberts, or Da Costa's "Medical Diagnosis." The last is little known in this country, and yet every young practitioner should have it, and study it; and the more he studies it, the more he will prize it.

You will find such study print "typhoid fever" on your mind in a manner worth any amount of "cram" for an examination: and further, you will get the subject up intelligently, instead of having a mere parrot-like acquaintance with it. Follow the fluctuations of the thermometer; learn to note the morning and evening temperature, and compare it with the first case of pulmonary phthisis you come across; and also with the next surgical case you see which has a temperature chart, with its "pus" fluctuations. You can ask after any source of the fever, local or endemic; if she has been away anywhere to get the poison. And do not run away with a crude opinion formed from some statement which will not bear handling. Do not create the impression that your informant is lying; only impress them, and yourself, with your carefulness and love of accuracy.

This, my young reader, is not unimportant. When people are telling the truth, or what they believe to be the truth, they resent any such imputation. On such a matter they are not likely to have any motive to tell untruths. If it was a case of disputed pregnancy, then you could be as sceptical as you like about any statement made; whether spontaneously proffered, or squeezed out by cross-examination. Then it is not unwise to follow Dr. Robert Battey, of Georgia, the enterprising surgeon, who has made "oophorectomy" a lawful operation—"Always believe a young unmarried woman with abdominal tumour, of high social position and unimpeachable virtue, if she has been watched over by a platonic and abstemious young cousin of the male persuasion, while the mother went out, to be pregnant!" Such circumstances, or any other where an unmarried woman is suspected of being pregnant, palliate a little tough lying, which is generally practised in such cases. And if you are the prudent young man I hope you are, you will keep your own counsel, and just remark, "In these cases the suspicion of pregnancy must always be entertained, you know!" If this is not sufficient to quiet the folks, just feign some diffidence, if you do not experience any, and say, "Well, I am not quite sure; I think you had better consult some older practitioner!" mentioning any

man of good repute in the neighbourhood. This is much the wisest course. It is no particular concern of yours—you need not defend your reputation for professional skill; if you are right, time will bear witness for you. But, do just remember that if you have got a little heated and rapped out some hasty observation, and that young woman's abdominal tumour disappears, no matter how, her indignant relatives will threaten to prosecute you for slander, and make it pretty warm for you, I can assure you. But, on the other hand, you need not distrust the *bona fides* of any information given you about the origin of a case of typhoid fever.

CHAPTER III.

THE SICK-ROOM.

THE friends of a patient cannot, as said before, be judges of the amount of your actual knowledge; still, they will form their opinion of you, and of your skill, from the manner in which you conduct yourself. They will estimate the value of your physical examination by the pains you take. Now, it is within the capacities of the veriest dolt to take pains; he can do that at least! There is no excuse which is valid for not taking pains. Yet this is where the young practitioner most commonly slips. He jumps at his conclusions; that would not in itself be so flagrantly bad, but in so doing he ignores all else, or neglects to go over the case thoroughly. Consequently when the friends of the patient ask for a consultation, he bristles up, and takes up an aggressive attitude: are they not satisfied? they can call in some one else if they are dissatisfied! He usually, or too commonly, adopts a "hoity-toity" air, or poses as an injured individual. Yet, my good young friend, if you will allow me to call you so, just analyse yourself a little more closely, and you will become conscious that you are afraid the consultant will find out something that you have not noted. There is the still, small voice of conscience to be heard by a fine ear. Yet you are a young man; probably you have done nothing very particular to command their confidence, or perhaps they are stupid old country-people who take a long time before they give their confidence to any one, and then perhaps not very wisely; but anyhow they prefer a name with which they have been long familiar. Is this any matter for surprise? The patient's may not seem a very valuable life; but life is sweet to most, even

the humblest, and there may be many affectionate ties betwixt the apparently uninteresting invalid and his or her relatives and friends, of which you can know nothing. A ready acquiescence will be most graceful on your part, and acceptable to them.

Excuse this little bit of sermonising—it has something to be said for it. The student sees a patient in the hospital: he is a number in a ward: his friends are people who come bothering asking questions, or wanting to see him at inconvenient hours. When he goes to private practice he is apt to carry a good deal of the hospital house-surgeon about him—I am not insinuating that this is wrong; but certainly it is sometimes injudicious. A hospital patient is the recipient of charity, and must conceal his feelings, unless flagrantly outraged. But when the fully-fledged owner of a diploma steps into a country village, he does not always realise that he is "upon trial." A neat brass door-plate is a nice object for its possessor to gaze upon; but the heavy-looking man driving the cows past the door upon which it is mounted, is not so profoundly impressed; probably, in a vague indefinite way, recognises the advent of a new neighbour—"A young man fresh from walking the hospitals, I reckon!"

Well, now, when called to a patient, attend as soon as conveniently may be. Some handicraftsmen think it the thing to keep every job on hand as long as possible—looks like plenty of business, they think. Yes; but plenty of business is far better than the semblance. The one is the reality, the other is the shadow. Don't fall into so transparent a wile! Remember, it is no longer your opinion about other people which has to be considered; it is other people's opinion about you. Turn about is fair play! So don't stroll into the surgery about 10 A.M. in your slippers, if you are a prudent young man. That might pass, or be passed over once; but it is out of place as a practice.

When you enter the sickroom, it is your duty to be sympathetic. The tragedian may have just come from the most mirthful society, the comedian's heart may be breaking at the last parting from a loved one; but

neither manifest anything of their inward feelings when they don the buskin, or watch the curtain draw up. So be sympathetic. Be circumspect; cause as little inconvenience as may be in putting down your hat and umbrella. Cottagers do not possess halls and umbrella-stands, but they have feelings. Be cheerful, if possible. Your visit is a much-looked-for event—do not forget that. Indeed, it is the event of the day to the patient. Say she is convalescing after childbirth. You can be cheerful under those circumstances. "How are you to-day, Mrs. Greenlanes? How is the baby?" Don't forget the interesting little stranger whose advent is the cause of all the excitement and bother. "Have you slept well? Have your bowels been open?" "No," she replies. "Do you feel uncomfortable, or not?" "No, I am quite easy, thank you!" If, on the other hand, she replies, "I feel very uncomfortable indeed," look to see what there may be to cause this. "How is the discharge going on all right?" An affirmative answer. Perhaps there is some flatulence; just percuss the abdomen lightly. Ask, too, "Have you any difficulty in making water?" (Now if the patient has any difficulty, just instruct the nurse to press over the bladder when the attempt is made, and you will not often require to pass a catheter—a very unpleasant matter for both you and the patient; or if she says there has been some arrest of the discharge, have some hot cloths put to the vulvæ at once, and without delay.) Ask, then, "Have you any appetite?" A cheery answer puts you at your ease about the mother.

Then turn to the baby. Ask—"Does baby suck nicely?" If the answer is in the negative, examine the nipple; sometimes it requires a nipple shield, or a little expanding with the breast-pump. Then comes the momentous question—"Is the baby tongue-tied?" If you do not put it, the mother or the nurse will. It may be so hindered in its efforts; but usually it is only clumsy in its first attempt at its new task. It is a legitimate lying-in-room joke never to cut the frænum in a girl-infant; it being taken for granted a female always acquires the use of her tongue. If a boy, it may

be necessary. Having seen to the baby; tell the mother to keep very quiet in bed for a few days; and order her not to have too much company during the time. If there are older children, it is permissible to ask the youngest that can talk, "How do *you* like the baby?" Of course, the young folks have their opinions, which probably vary. It is going out of fashion now to elicit opinions as to how the baby came: whether the doctor brought it, or it was dug out of the apple-tree root. These were matters upon which the child-mind was once much exercised; but nowadays it is found to be as well to avoid any such speculations, as at times leading to awkward situations.

Some little time ago I asked two young medicos, each having been a resident house-surgeon, the following question. "Suppose you are visiting an old gentleman of about sixty years of age, who is recovering from a sharp attack of bronchitis, and can sit up about three hours a day; you find him wrapped in blankets in his arm-chair, and a sharp-looking old lady sitting near him reading the newspaper to him. What will you ask?" Each got so far as to ask, "How are you to-day?" One got a step further. "How is your cough?" Then the interrogation ceased—the well of inspiration dried up! Yet neither were fools; they were, in my opinion, fair average specimens of the young hospital medico contemplating going into practice. When asked what they would do, with the greatest alacrity they declared they "would have up his shirt and examine the backs of both bases (lung)." Now this would of course be hospital practice; to neglect to do so would be to run the risk of a "wigging" from the visiting physician. "What," I asked, "with the old lady sitting there?" Neither seemed to take the old lady into account at all; that part of my question was quite superfluous, apparently. Both looked a little taken aback at their want of gallantry in overlooking the old lady. In actual practice that old lady could not be safely ignored. She had seen lots of doctors before; was there to form her opinion about the new doctor, as one factor in her presence there, in all human probability. She had her *rôle* to play. Pointing

out that such action would involve disturbing the old gentleman very much, deranging his blankets and chilling his back, and probably upsetting his temper, and was therefore not to be done without good reason for it; I went on to say that perhaps his shirt-tail might not be quite in that condition that he might care about the lady seeing it. This seemed quite a new light on the subject to both! Now there is such a thing as negative instruction; and this carries with it a lesson. Careful observation of the old gentleman, and especially the proper use of the watch in taking the proportion of the rate of the pulse and the respiration (as described at p. 49 of "Semeiology") would soon tell whether or not such examination was called for; if the respiration was mounting, then an examination was certainly indicated, and, if something was found to justify it, the patient would not mind the discomfort. But if nothing came of it, he would be apt to regard the doctor's visit as a nuisance. So never unnecessarily strip and distress a private patient; when you see them, you are supposed to have learnt your profession—they do not pay you for your attendance in order that you may perfect your education! Your hospital patient reconciles himself to his fate in the fervent hope that you will develop into a very clever young man; and, stoically or not, submits to the inevitable. Do not pursue blind alleys, which lead nowhere, in your investigations; they do not impress the patient favourably. Then old ladies are not to be ignored; and it is as prudent to be civil to them, and do a chat about the weather, or other cognate subject of mutual interest. Why, bless these two guileless young souls, to make a good impression on that sharp-looking old lady was the most—far away the most important matter of the visit; if they only recognised it and knew it!

The conversation as conducted by an old family doctor of experience would have run on these lines; after an introduction to the old lady, conducted with all courteousness: "How do you feel to-day, Mr. Broadacres? —better?—yes, I thought so!" The old boy has been scanning him over to see whether he was better or worse:

he does not put his questions without weighing them first. "How is the cough?" "Easier, I think," says the patient. "Did you sleep well?" "Yes, on the whole. Had one bad bout at three!" "Have you had your breakfast?" "Yes." "Enjoyed it?" "Very fairly." "What did you have?" "A piece of boiled turbot, and a slice of bread and butter." "What are you going to have to lunch?" "I don't know." Old lady puts in her oar. "I have brought some oysters, doctor. May he have some?" Of course he may; and a neatly-turned compliment about her discretion, as well as her kindliness, wins the old lady's good opinion. Dextrous old gentleman that! He may not know his pathology, or be familiar with the microscope; indeed, he may be shockingly ignorant about glycogen, and not know a peptone from a proteid; but he knows human nature, and the practice of physic as adapted to gentlefolks, a precious sight better than you yet do; my promising hospital fledglings! Harmony prevails: golden opinions are obtaining all round. "Will he have a glass of Hock or Sauterne with the oysters?" That is an important detail to settle. Sauterne ultimately carries the day. The doctor is very *exigeant* about his promising not to stay up too long; orders the medicine to be continued: throws in a brief side inquiry about the bowels; finds they have not moved, so orders a pill to be taken at bed-time. Then he shakes hands with the patient with repressed emotion, telling him how glad he is that he is going on so nicely; turns round to the old lady, shakes hands with her with a distant courtesy, indicating his deep respect for her; and expresses his satisfaction at having made her acquaintance, with an unquestioning honesty and earnestness; bows pleasantly as he takes up his hat, and disappears: leaving behind a feeling of satisfaction and an impression that his visit is as welcome as a gleam of sunlight in a showery April day.

Such is the practice of medicine among the better classes: it involves good breeding, polished manners, keen observation, veiled by a pleasant urbane behaviour; as well as a kindly interest, as indicated by the turn of the conversation. Yes, my young friend, the reader, your father may spend a lot of money upon your educa-

tion ; but that is a part of it you will have to learn for yourself, and it will take many additional years for its acquisition ; but it will be of incalculable value to you, when you have acquired it.

Or you are calling upon a girl of fifteen who has been down with pneumonia, and is recovering rapidly : it is in the morning. You ask—"How have you slept?" "Had your breakfast? Did you enjoy it?" If an affirmative answer be given you know the patient is progressing satisfactorily ; and you can amuse her and instruct yourself by examining the state of the lung, and seeing how fast it is clearing up. This done you can proceed. "Well, do you feel inclined to get up?" "Very much!" or, "I should so like to." Now you remember quite well that though a patient feels very equal to getting up while still in bed, it becomes another matter when the attempt is actually essayed ; therefore you look as wise as you know how, and ask—"Are you going to be up wrapped in a blanket ; or are you going to be dressed?" "Going to be dressed, of course!" is the answer. Now, dressing taxes the patient's strength ; and then, when the patient has sat up till tired, the undressing is often very wearying ; and instead of being delighted at having been up, the patient complains of exhaustion, and probably sleeps badly after it. Now, it is very desirable that a convalescence never be checked, but go on progressively. Therefore, for the first day or two the patient should not be dressed ; if the being up is well borne, the dressing may follow. But insist that the first day of the dressing the patient only be permitted to sit up an hour ; allowing for the dressing and undressing.

In the same way you act cautiously when the patient is well enough to get out of doors. You remember that the patient has been in bed, or in a warm room only, for some time ; and you also remember what your physiological lecturer told you about the rabbits that were kept some time in a warm chamber, that they did not conserve their heat well for some time after, and that their temperature fell in consequence. Very well, remembering this, you ask—"How far do you intend to go?" "Are you going to be driven in an open or a covered conveyance?" Or

if a stroll in the garden is contemplated, you bear in mind the patient cannot walk quickly enough to keep up the body heat, and so insist in either case about the necessity for plenty of "wraps;" the lighter the better, as the patient cannot well bear any great weight. Yes, and make a point of inquiring into the character of the wraps, their sufficiency and warmth. Then add any advice the circumstances require, or your wisdom may suggest; and do not be at all surprised if your caution is liberally discounted, and the patient gets some cold, despite your reiterated warnings and all your good counsel.

A little physiological knowledge often serves you well in practice; if you have not only got the knowledge but know how to apply it. And to remember how the rabbits, after an experience in a warm chamber, could not keep up their body-temperature, is often to be able to give sound advice; and such little bit of physiology will be useful to you fifty times for once you will have an opportunity of airing your acquaintance with the origins and insertions of the muscles of the thigh, or of comparing the right and left astragali; indeed, than all your lore about "the dry bones of the valley of Ezekiel," upon which such a terribly large proportion of your student time is expended. Your anatomy may be the cardinal matter of your education in an antiquated system of medical teaching, and while before an examiner; but you may take my word for it, without requiring corroborative evidence of its validity, your physiological knowledge is what will stand you in most stead when you get into practice; and the more you know of the normal processes of the body and the facts taught by experimentation, the better practitioner you will be. Remember, also, that there is much told you by your physiological lecturer that is intended for the examination table, as well as for use in daily practice. You will hear much of the propriety of giving a part "physiological rest," as in laying up a sprained ankle; putting a strained joint into a leather case, so as, for the time, to prevent its being a joint; or even applying a Sayres' jacket to a bending spine: but you will have to reason out for yourself the desirability of sending a patient to bed for several days after a severe

shake which has involved the contents of the skull; or even of shaving off the raised prominences of cuticle in a scratch, the results of which are very grateful to the patient; but don't take my word for it on this little matter, but just try it and see. They catch at everything which comes near them; shave them off, and all such irritation is avoided; the scratch is rendered comfortable and the healing process goes on kindly.

CHAPTER IV.

PRACTICAL EXAMPLES.

Now my reader and I, my vanity inclines me think, are getting on sufficiently intimate terms to pursue together this subject further, without falling out with each other, or quarrelling. In this chapter some well-marked examples of the instances where incisive questions may be asked with advantage, will be given ; but it must not be supposed that any attempt is being made here to exhaust the subject, or to go into abstruse matters. Such illustrations only will be given as will demonstrate the practical utility of well-placed interrogations.

We may commence with the head. A patient complains of headache. You first ask him, "Where?" He refers it to a certain part ; you examine it carefully, inspect, feel it. You see some injury, or bruise. Your way is then clear before you. There is nothing to see, but you feel a lump. Is it a bruise or a swelling—osteal or periosteal? Now you know that the characteristic of such pain is that it is nocturnal. So you ask, "Is the pain worst at night?" The answer is in the negative. Keep your eye open to the possibility of a neuroma, though they are not commonly seated on the scalp. But the patient replies in an energetic affirmative. You then immediately suspect syphilis ; nevertheless, it may be due to injury, or other cause, This form of pain is connected with the skull rather than its contents. Rheumatism of the scalp is not a rare affection. In many cases, however, you see or feel nothing to help you.

So you ask the patient to place the hand on the seat of pain. It is placed over the forehead. You then suspect

some derangement of the abdominal, or pelvic viscera. Or it is placed on one side of the forehead mainly. You then remember the neighbourhood of an eye; and that want of perfect accommodation of the eyes leads to straining of one or both, with consequent headache. So you ask, "Is your headache made worse by reading, or by using your eyes?" Often the patient needs pressing on this point. If it is so, send the patient to an oculist. If a distinctly negative answer be returned, inquire after the teeth. A decayed tooth may be the exciting cause. If the hand be placed over the side of the head, then examine the ears, and test the mastoid processes.

Or the patient places the hand upon the vertex. Vertical headache is linked with cerebral anæemia, and, therefore, with depression of spirits. Ask, "Are you low-spirited?" Then, "Do you feel inclined to cry?" An instantaneous suffusion of the eyes is an answer more eloquent than words. Ask if there be "face-ache," usually on the right side; or, "pain under the heart." If so, then you have fair evidence of the malady being truly neuralgic. Pain in the back of the head is suggestive of venous fulness; it may, however, be associated with the occipital nerves. Nerves are apt to be pressed upon where there is periosteal swelling of the foramina, through which they pass. In pain in the occiput, in infra or supraorbital pain, look out for this cause, viz., the nerve being "nipped." The pain is associated with one nerve; but it is not the gusty intermittent pain of neuralgia; it is always there, but worse at nights, or whenever the blood-vessels are relaxed. (Such pain is found, too, in spinal nerves at times.) Don't be deterred by the apparent difficulty in making the diagnosis; keep your head cool, and think about what you are asking, and why the thing should be so; in other words, approach the difficulty intelligently, and the apparent insurmountableness will diminish. In tumour, abscess, or basilar aneurysm, pain severe and agonising is usually present. When there is general headache, with a flushed face and suffused eyes, with restlessness, meningeal inflammation is suggested, and there is also excitement in the vascular system.

One form of headache is well-marked, viz., "brow-ague." The patient places the hand over one or both eyebrows. Remembering the rhythmic character of malarial neuralgia, you ask, "Does the pain come on at any particular time of the day?" The patient mentions a certain hour. You make sure about the correctness of the answer, and then diagnose "brow-ague." You give quinine in full doses, one before the time the pain is due; and the case gets well. You may thus score in a case that has been intractable because its real nature was overlooked.

Your inquiries about the pain not clearing up the case, you proceed, "Have you any giddiness, or swimming in your head?" The answer is, "Yes." Ask if the tendency is "to turn to one side always." If so you have Menière's disease to deal with, in all probability; so ask for "deafness," or "ringing in the ears." At other times the pain lacks this association. Ask, "Is it brought on by exertion?" If so, a weak or injured heart is probably present. If you can find no cause, and it is not worse after meals (gastric vertigo) it is significant of coming epilepsy, or even structural changes in the brain.

In order to form some idea as to its origin, ask, "Have you any loss of memory?" The patient thinks not; so ask, "Can you remember names, or not?" The answer is often, "No, names bother me!" Then ask, "Do you find your memory playing you tricks?" If you ask, "Is your memory failing?" the patient becomes alarmed and nervous. The phraseology here recommended being strange, it does not so upset them. He admits it. You then ask after the motor system. "Have you any loss of power in your hands or arms?" If there is any such loss of power, then proceed, "Have you any numbness at times?" If the answer be in the affirmative, test with a pin. You will thus arrive at some idea of the cause of the brain-impairment. Probably there is general impairment; perhaps from overwork, needing rest; or malnutrition from dyspepsia, or mal-assimilation in the digestive organs. The older the individual, the more grave the case.

Or there are fits of "unconsciousness." There may be

petit mal, or syncope from heart failure. Long syncopal attacks in middle-aged persons, feeling well in the interval, almost always tell of aortic stenosis. Don't forget that, if you please. Then they are commonly *petit mal*. Here they are usually frequent, recurrent, and with or without more severe attacks. For an answer on these matters you may have to ask some one else who associates intimately with the patient. Ask the patient, "Do you bite your tongue?" When the tongue is bitten it is very significant, so examine it carefully for scars, telling of past seizures. Or you see a patient in bed with hemiplegia and incapable of speech. You try to arouse the patient. Pain is felt, you note; if told to swallow it is done. Here you know you have to do with softening; there is not true apoplexy. In apoplexy the consciousness is really abolished. Or you find a patient unconscious without any distinct paralysis. You inquire of those around, "Is this the first attack?" If there be an account of a previous attack and "stroke" after, then you probably have apoplexy to deal with. Or you find that some one has seen a bottle about; get it. Probably there is a narcotic poison in the case. Or you suspect uræmic convulsions. Ask for the patient's water. If any be available, test for albumen: if present, the case is cleared. If none be at hand, go home for a catheter and draw some off. Then put the crucial question to the urine. It cannot speak articulately, but it can tell much at times of the greatest value.

Or the patient complains of "asthma." You remember that with many persons "asthma" stands for all forms of difficulty of breathing. So you proceed to elicit a little more. "Does it come on in fits?" you ask. "Oh no; it is constant!" is the reply. You know from this that the spasmodic element is not present. Where there is persistent dyspnœa in all probability there is emphysema. Look at the respiratory act, note the action of the muscles of the face. "Do you raise much phlegm?" you then ask. "Yes; a deal." Then you know chronic bronchitis is also present. "You are short of breath when you get about?" you follow up. Now it is quite clear that if a patient is short of breath

when quiet, he will be sorely scant of breath when he exerts himself. You do not therefore feel yourself very clever in asking this question; but it impresses the patient, and helps to give precision to your own views as they are taking shape. Next you wish to know how far the right ventricle is insufficient; so, having percussed the chest and found an increased area of dulness over the right ventricle, you feel the pulse and compare it with the action of the heart. You observe the heart is labouring, yet the radial artery is badly filled and compressible: it is fairly clear the right heart is labouring, and the left only sends on the small amount coming to it. So you follow up. "Have you palpitation when you walk or exert yourself?" "Yes;" the patient has. (He and those around him now begin to think you are a very sharp young man, and they will ask you about that sick cow when they see you out to your trap, or horse.) You then remember the relations of a slack artery and a full vein to the secretion of urine, so you fire another shot. "You don't make much water, do you?" To your considerable surprise the answer is "Oh dear, yes, a great deal." This may be so, but it is very unlikely: so you proceed. "Do you mean you often make water, or you actually make a great deal of water in twenty-four hours?" "I often pass water." "But it is not much altogether?" He replies, "No, only a little drop." You go on. "Is it high-coloured?" (remembering a scanty urine usually is a high-coloured urine). "Yes, like blood." You feel somewhat surprised, and insist upon looking at it. You find it high-coloured, but certainly not "like blood." Ill-educated persons never observe closely, unless it be as to the genuineness of a coin, or something connected with their daily occupation—these they can usually note closely enough. So you elicit a corroboration of this generalisation, and find out the bulk of urine really is small. I don't think the severest censor of youthful enthusiasm would denounce a little, just a very little natural exultation at this point; so you might flap your wings and crow, and show how your question brought out the facts. (The idea of asking you about that cow grows stronger, as an illustration of their wax-

ing confidence in you; a compliment you probably will not appreciate as you ought to do, unless familiar with "farming folk.")

Or the answer is, "Yes; it comes on in fits, and is worse at times; but I am always short of breath." Now paroxysms of dyspnœa are common in mitral disease, when the lungs become congested with blood, and the thoracic space is thus diminished. You follow up, "Do they waken you up at nights out of your sleep?" "Yes; they do." There may be cardiac disease from mitral valvulitis, or decay of the muscular walls. Look and see! At other times there is true spasmodic asthma coming on suddenly, and lasting a variable time. If they last for some hours, then true asthma is probably present. Cast your eye over the patient. True asthmatics are generally a lean kind of folk—rarely burly beings; these are the chronic bronchitis patients with emphysema, with or without heart complications. One crucial test of this complication of "fits" of dyspnœa with persisting shortness of breath, is this, "Is the fit brought on by exertion?" In true nervous asthma this is never, or hardly ever, the case; while in chronic bronchitis, with emphysema, such association is constant. But make careful physical examination accompany your interrogations; one is the complement of the other. True asthma is not uncommon with emphysema, the emphysema being due to the violent respiratory efforts entailed; so do not be thrown out, or off the rails by the results of your physical examination. Nor will the presence of a mitral murmur necessarily disprove the fact of the chief mischief being in the lungs. Your questions and answers will help to keep you straight amidst the apparent maze of phenomena.

Or you are told the chief complaint is "palpitation." Of course your first impression is "heart-disease." Quite right; but just remember palpitation is rather linked with a neurosal condition of the heart than with actual disease. In an elderly person actual organic disease is probably to be discovered; in young persons, and especially young women, it is almost certainly "functional;" but it may be due to mitral disease,

especially in little girls. Now your first question is, "Does it come on with effort?" "Yes; it does," is an answer which will suggest to you the probability of actual disease. This I wish to impress upon you. Having paid much attention to the diseases of the heart, and consequently seeing a great many cases, I find that the valvular diseases of the heart as indicated by murmurs, are very well understood, as regards their diagnosis by physical signs. But it would not be the truth, nor anything like it, to say, that the condition of the heart as a muscle is equally understood. Now in all cases, valvular disease, dilatation, or debility from malnutrition, where the defect is lack of muscular power, effort produces palpitation, with a rapid pulse. Now the answer will tell you pretty well the direction your examination must take. But if the patient answer, "It does; but it comes on at other times," then you proceed to ask, "What other times—in your sleep?" The answer is, "Yes." Now you remember that attacks of dyspnœa are very apt to come on in the night in cases of organic disease of the heart, especially after supper has been taken. So you continue, "Had you an attack last night?" "Yes; a bad one." Then ask, "What had you for supper?" You will usually find that the supper has been an unsuitable one (direct therefore a light supper only). You say, "You must give up your supper." This rouses violent protestations. So you may proceed, "Well, you can choose for yourself betwixt the supper and the attack; they go together. Go without the one, probably you will be without the other. Have the supper, and you will have the attack with it." (This is most frequent when the nocturnal attack involves "dyspnœa" as well as "palpitation.")

When the patient complains of palpitation on going upstairs, a very common complaint, you suspect cardiac asthenia. But when you are told, "Any fright or upset brings it on," then you suspect you have a neurosal heart to deal with. "Do you drink much tea?" is a very proper question, particularly with women. "Do you smoke much?" with a man, especially when his teeth are brown. At this point listen to the heart; if its

action is violent, it is in all probability a neurosal palpitation. If its impulse is forcible and diffused, and you also hear a murmur in a young woman, look at her eyes to see if they are prominent; look at her neck to see if there be goitre. Ask, "Are your eyes always prominent?" If not, "Are they sometimes worse than at other times?" Then the neck, "Is your neck always thick, or at times only?" If so, then you have got a case of ex-ophthalmic goitre to deal with. Finally ask, "Are you excitable, or only at times? Whom do you quarrel with usually?" If married, her husband is usually the object of her wrath; if not, her favourite brother. But remember palpitation when brought on by effort indicates actual muscular asthenia, either a dilated ventricle, a fatty wall, or mitral disease. Even when you find a murmur, the effect, or want of effect produced by effort will guide you more safely as to the extent of injury done than the loudness of the murmur. Bearing in mind the fact that palpitation is rarely found with disease of the aortic valves, but is certainly intimately linked with mitral disease, you make your examination, and put your questions accordingly. A plump woman about the change of life will have often a heart which certainly palpitates on effort; but which also is readily set off by a start or an upset. So put your questions guided by this fact. You say, "Your heart beats when you go upstairs?" "Oh, doctor, I can't get upstairs at all!" is the common response. You sympathise with her, if you are a gentleman, as I hope you are, or try to be. Then you say, "Anything coming suddenly puts you out, and gives you palpitation?" "That it does, indeed!" This is all the more important, because in consequence of the fat on the chest-walls and the large mammæ, you can make little out from physical examination except auscultation; and perhaps not much from that.

When you see a patient breathing with difficulty, propped up in bed with many pillows, or even, perhaps, a chair supporting the back, or sitting up in a chair, usually either an arm-chair, or an ordinary chair leaning the arms upon the back of another chair in front, it is quite safe to ask, "Is your breathing very bad when you

try to lie down?" "I can't lie down!" the patient gasps, often irritably. Then remember that orthopnœa goes with an embarrassed right ventricle, and put the questions just given. One great cause of orthopnœa is the pressure of elastic gas in the stomach or bowels upon the diaphragm, so you ask, "Are you troubled much with wind, or flatulence?" according to the social position of the patient. "Terribly!" is a common answer. Then you do not forget to examine the abdomen and percuss it, not only to satisfy yourself, but to convince the patient. Now a very carping critic might say there is an element of immorality, a tendency to humbug, in putting these questions when the matter is obvious. I deny it: there is no more humbug in these questions being put, than in asking a woman "Have you toothache?" when you see her lower jaw bound up with flannel. You must not only know what you are doing, but you have also to let the patient see that you know. Yes; and remember this is more necessary as you go north—more north than south the Thames, more essential still north the Trent: it is needless to say absolutely necessary north the Tweed and the Solway.

Or you are summoned in haste to a person who has "got up a lot of blood." Now you are brought face to face with the question, is it a case of "hæmoptysis" or "hematemesis;" and it is not always as easy to make the distinction in practice as it is on paper. You scan your patient over; if the brand of phthisis is obviously on him, or her, it is probably hæmoptysis; but the blanching of a sharp hematemesis following the anæmia of gastric ulcer produces a ghastly aspect not unlike phthisis. If the patient be well enough, put the questions direct; if not, then to those in attendance. First, "How much blood have you got up?" Ask to see it. Look at the amount; then, in hematemesis, it is usually considerable and dark, being acted on by the gastric juice. So you say, "All at once?" In hematemesis "there is not commonly more than one act of vomiting." If an artery be opened by an ulcer the blood may be florid. In hæmoptysis the blood comes up rather from time to time; except when a pulmonary vessel is eaten

into by ulceration, or in the case of an aneurysm into a cavity giving way, and then there is usually no opportunity for any recurrence. Now, having noted all you can by the eye, you proceed. "Had you any tightness round your chest?" and again, "Had you any salt taste in your mouth before the blood came up?" There are two most important points in connection with blood spitting, so put them clearly. "When blood is vomited from the stomach, it is preceded by a feeling of weight and uneasiness in the epigastric region, and sometimes by decided nausea." (Da Costa.) If negative answers have been returned, proceed: "Had you any sickness or nausea in your stomach before the blood came up?" This will help to clear the diagnosis, if an affirmative answer be elicited.

This is all very well, but there is another matter of great moment, and it is this: "hæmoptysis" and "hematemesis" are often only vicarious menstruation, so ask the patient, if a woman, "Is this your time to be unwell?" Don't be driven off the track by any evasive answers: get a decisive answer if you can. If it is so, then ask, "Have you got up blood before at your poorly times?" If so, your mind is much relieved. Further, in my personal experience, "spitting blood" often goes with constipation. One of the commonest experiences of an out-patient-room at a Chest Hospital is to find an old patient, with a consolidated lung-apex, returning and complaining of hæmoptysis, after staying away awhile and being without medicine—when that medicine has been laxative. Remember this connection in all small bleedings, *i.e.*, under half a pint. "Are your bowels open?" "No." Then open them with a saline purgative. This gives relief. At other times the patient tells you, "It comes on when I stir." Then ask quietly, "Why do you move? why don't you keep your bed?" You will find a form of acute congestion of the apex, where any movement causes the blood to flow readily, which is usually very amenable to treatment. Always, too, remember the amount of blood you see does not represent the amount of hæmorrhage; a quantity of blood flows into the air-tubes, or into the intestines, as

the case may be. Always ask to see the mouth, and examine the gums, fauces, and throat for any cause of the hæmorrhage; especially when the loss is small but persisting. These are just the most difficult cases to diagnose. A free hæmorrhage generally has associations which clear it up. At other times, in middle-aged people mainly, there is a cardiac lesion, usually mitral. But well-put questions will often serve you in good stead in a doubtful case. Be very careful always to inquire about any effort, as it is effort which is usually linked with the rupture of a vessel.

There are many other points that might be discussed, but it is impossible to attempt them in the space at command. Enough has been given to demonstrate the importance of the information derived from well-put questions. When you come to the maladies of the alimentary canal, then questioning becomes of still more cardinal importance. The patient complains of sickness, or pain in the stomach after food. Now be sure to ask, "Will you put your hand on the seat of the pain?" A "cockney" patient always complains of pain in her "chest" in dyspepsia; "chest" with her extending down to and including the navel, and this is the reason why so many cases of abdominal trouble find their way to a Chest Hospital. Having determined the seat of the pain, then ask, "When do you have the pain; after food?" Usually you get an affirmative answer; but it is not so easy to get at the precise time after food at which the pain sets in. Yet this is important. If quickly there is gastric disturbance; if an hour or two after food then you are entitled to regard the duodenum as being implicated. Pain after food, the late Dr. Leared held, indicates deficiency of gastric juice; while flatulence betokens asthenia in the muscular coat of the stomach. In other words pain tells of defective solvent power (indicating pepsin with an acid); flatulence, inefficient rotatory power of disintegration (calling for strychnia). Be this absolutely correct or not, it is worth keeping in mind. So you ask, "Have you much pain?" Then, "Between the shoulders?" Women mostly have pain betwixt the shoulders in dyspepsia. Now look at the tongue and see if it be natural,

raw, and irritable, or foul. Then follow up, "Are your bowels regular?" Now a great deal of mistake is made in this simple question. Each person's notion of their bowels being "regular" means what is their individual habit. I remember an old Irishwoman complaining of being "purged" because her bowels were open "once a week." Her habit, it seemed, was "once in three weeks." This is an extreme instance, but it illustrates the necessity for ascertaining in each case what "regular" means. Find out precisely then. Remembering too that the treatment of indigestion is hopeless if the constipation be not relieved.

So far the case is one of dyspepsia; but what its precise nature, has yet to be ascertained. So ask, "Do you ever vomit your food?" If "No" be the answer, there is probably no distinct lesion. If "Yes," then proceed cautiously. "How long after you have taken your food does the vomiting commence?" Perhaps the answer is "At once!" This is significant of gastric ulcer, the movements of the stomach dragging on its base and causing pain. So you follow up. "Does the vomiting give you relief?" The answer is, "Oh, I am easy at once, after being sick!" Now the case is pretty clear. Still, it may be "catarrh." In this latter case there is a quantity of mucus poured into the stomach, consequently there is "morning vomiting," on getting out of bed, of the amount accumulated in the night. So you ask, "Are you sick first thing in a morning?" Yes, the patient is sick. Now a very common symptom is morning vomiting in connection with bronchial affections. The bronchial mucus also gathers in the night, and on getting up the change of posture causes the masses to shift a little, and then a series of coughs is set up to dislodge them from the air tubes. Such coughing commonly ends in vomiting. So be clear about the vomiting. "Do you cough much?" "Yes; it is the cough which brings it on!" But in the vomiting of gastric origin there is little cough, though "stomach cough" is no unusual phenomenon, from the fibres of the vagus going alike to stomach and lungs. Now morning-vomiting is linked with two well-known matters, *viz.*, "pregnancy" and "drinking."

I heard it well put the other day to a man whom the other physician and myself knew to be a drinker; my *confrère* said, "There are two associations of 'morning vomiting,' 'pregnancy,' and 'alcohol.' I think we may eliminate the first in your case!" This was a neat, inoffensive way of putting it. When there is catarrh there is a quantity of mucus vomited. The food is wrapped over and over with mucus by the movements of the stomach, and this takes some time; consequently the pain and discomfort does not come on immediately, as in gastric ulcer. So you get the answer to your question as to "the time of the pain." "Oh, it comes on a short while after a meal!" "Is it relieved by vomiting?" "To a great extent; but there is a feeling of weight and soreness left." These are the lines to go upon. Ask that the next vomited meal be kept. In catarrh the food is "half digested, mixed with strings of mucus;" in ulcer it is more speedily ejected, and therefore carries with it few traces of the digestive act. This will not only tell you much, but will indicate to the patient's friends that you take pains, and do not do your work in a slipshod manner. Now, while you are asking these questions you are thinking; or, at least, I hope so. Gastric ulcer is common with young women; alcoholic indulgence with men of middle age rather. But such generalisations must not dominate you too far. A middle-aged man with gastric ulcer is a pallid, unhappy-looking wretch; the toper carries a certain bulk and a "flush" usually. When a young woman takes to drinking her liver quickly enlarges: examine the liver then, when the case is doubtful. "Gastric cancer" is not, as a rule, an affection of early life. Here we have the common symptoms, *i.e.*, those common to the diseases of the stomach, *viz.*, "pain," "vomiting," "tenderness," and "disordered digestion." You ask about the pain, then, and elicit the answer, "No it is not quite relieved by vomiting." You proceed. "How long after food does the vomiting come on?" "About a couple of hours." You remember cancer of the stomach is usually located in the pylorus. The pyloric ring does not relax till the gastric portion of the digestive act has proceeded some length, consequently

the pain does not come on till the ring relaxes. The patient usually looks "ill." Remembering that gastric cancer is commonly accompanied by acid fluid poured out freely in the stomach, you ask, "Do you ever vomit a quantity of sour fluid?" If such is the case it is very significant. Now there remain two semeia which will help you, *viz.* (1), extreme flatulence, and (2) the cancerous tumour. Examine for them; if you can feel a tumour at the pyloric end of the stomach, little doubt can remain.

There is often, too, "dilatation of the stomach," which may also occur without cancer. Beyond the physical signs there is the vomiting of enormous quantities of food which have accumulated, perhaps for days. But if you can clearly distinguish betwixt "simple indigestion," "gastric ulcer," "gastric catarrh," and "gastric cancer," you are a fairly good student. And this you might be able to do. But clear though a case may become by careful questioning, examination, and reasoning thereupon, it is very easy to make a mistake—how easy, any practitioner of experience can tell you; either from some mistakes of his own, or those made by another and detected by him.

N.B.—The man who is always telling of the mistakes of others detected by himself has an unwholesome mind, and in my experience very rarely knows his profession well. Very often his discoveries are themselves mistakes, and if you hear the opinion of others about him, you will find they have their account of mistakes made by him, and usually no short list; and have very little confidence in his diagnostic power. He has a large percentage of extraordinary cases of which he is very proud. An ordinary pregnancy often in his hands becomes a wonderful tumour, until the progress of time reveals the actual facts.

Cerebral vomiting is usually free from the symptoms of indigestion, and comes on suddenly. It might then be confounded with that of ulcer; but the absence of gastric symptoms and the presence of "brain" symptoms will usually tell the difference. When the patient vomits suddenly, and answers "no pain," "no nausea," you must

be on your guard as to a cerebral cause. "Vomiting" is also produced reflexly by pregnancy, uterine or ovarian mischief, by a blow over the testicles, or orchitis, and by a calculus in the kidney.

Or you are called to a case of "inflammation of the bowels." You find the patient complaining of intense pain in the bowels. Remembering that an inflamed serous membrane cannot bear a touch, while colic is rather relieved by pressure, you place your hand flat over the belly, and, pressing lightly, ask, "Does that cause you pain?" "No," is the answer. Press a little harder, to be sure, and ask again. "No," still? There is no inflammation. (In the so-called "hysterical peritonitis," intense suffering is caused by the slightest touch. Divert the patient's attention, say to her head, for instance, point to the parting of the hair, and ask after a "stabbing" pain there: while the attention is so directed, press on the belly. There is no complaint of pain. But if there is really inflammation present, the pain so produced will soon draw the attention of the patient to it.) The pressure will soon diagnose the cause of the pain correctly. Then ask, "Is the pain constant, or does it come on in spasms?" "It is constant." Then inflammation is probably present, or, "It comes on worse at times, and nearly goes away"—this shows the peristaltic action of the bowels is involved. Colic is spasm of this muscular fibre, consequently it comes on in gusts. and is intermittent. So is abdominal neuralgia; but this does not come on so suddenly. All neuralgiæ have "gusts of pain;" this "gustiness" is pathognomic indeed.

But when you ask as to the exact seat of the pain, you will come to more localised affections. So be particularly careful. "Where is the pain?" you ask.* "It is in the navel." "Are you quite sure about it?" inquire. "Yes." Now remember that when the intestines are implicated, the pain is especially referred to the navel—"navel"-pain is "bowel" pain. So look for hernia, ileus,

* Though this has been alluded to before at p. 11, it is well to go over it again here.

twisting, or stricture. Take pains; leave no stone unturned. Then at other times the pain is referred to the gall-bladder. This corner of the bowel is full of difficulties, so go warily. "Is the pain very severe at times?" "Yes." Now, the expulsive pains of the gall-bladder, extruding a gall-stone, are recurrent: when severe, there is apt to be nausea and vomiting. Ask after these two accompaniments. Recurrent pains in the region of the gall-bladder are mostly due to gall-stones, but not always. This corner of the colon is sometimes, perhaps frequently, the seat of recurring pain from the difficulty of getting the fæces to take the turn in the bowel kindly. So ask, "Does the pain extend downwards?" at the same time feeling and percussing the ascending colon. If the patient answer "Yes," and you find dulness and fulness, give a dose of laxative medicine and an enema, and see if the whole matter will not disappear. If it does, you may be easy about "gall-stones." Now the pain is sometimes lower down, in the right groin almost. You then know that the cæcum is involved. If there be a high temperature, then tenderness, any pain or pressure, will suggest typhoid or enteric fever. Listen if there be any gurgling on gentle pressure, when you press, and ask, "Does this cause pain?" At other times there is greater tenderness, with considerable dulness on percussion, so look out for typhlitis. If a woman, just be sure you have not got a tender ovary to deal with; because a tender ovary, either on right, or, more often, left side, will stop the movement of the bowel (reflexly), and so cause constipation. But the student must not expect to be able to settle a point like this except by infinite pains, reading up his book on "Diagnosis," thinking over the case, and examining again and again. It is not always possible to decide upon a case from one examination. Do not be ashamed to admit that you are not inspired, that you only claim human, not superhuman powers. Remember always the belly is a very difficult region for all, old and young.

Now, when you say to the patient, "What kind of pain is it?" and the answer is, "Like a cord drawn round me;" or, "It is like an iron band clasping me," just bear in mind that such "girdle-pains," as they are

termed, are pathognomic of the spinal meninges being involved, as by vertebral caries, or aneurysm pressing on the spinal column, or a tumour. Now, when you hear the patient give such a description of the character of the pain, just "pull yourself together," to use an equestrian expression, and put all you know to the front. You probably have a chance of distinguishing yourself; do not throw the opportunity away. Keep your head cool, examine the spine carefully, and you will find—something.

Now, there is another "belly-pain" which is common. The patient is in bed: restless, changing about to get ease, as in colic; but the pain is not in the bowels. The patient refers the pain to the left or right loin, shooting round into the bladder and the testicle. The pain is very severe, at times excruciating indeed. Sometimes it is very severe in the hip. There is sickness and vomiting. Now, the locality of the pain speaks of the ureter being involved. In fact, a renal calculus has slipped into a ureter. So you ask as to the seat of pain cautiously; then proceed: "Do you constantly feel an inclination to pass water?" The patient does feel this. "Does the testicle of that side ache?" It does; look to see if it be drawn up. "Did the pain come on suddenly?" "Yes, it did." Then inquire, "Have you had the pain before, ever?" If the patient has so suffered, it corroborates you in your view. When the stone slips out into the bladder, the "forcing" pains cease, merely leaving some soreness. So follow up: "Did the pain cease suddenly?" "Yes." Just another question, "Do you pass sand or gravel?" An affirmative answer is fairly conclusive. You may indulge in a carefully worded, yet favourable prognosis. If a negative, calculus is absolutely disproved. Ovarian pain has been spoken of before in chap. i. p. 15.

We will now take "pains in the back." A woman tells you she has pain in her back. "Where?" you inquire. "Betwixt the shoulders." Then proceed on the supposition that dyspepsia is present, and usually you will be right. But the answer is, "Over the loins." Now, this is lumbago; but a name does not settle the precise form. If the patient is a woman, ask, "Is the pain relieved by

lying down?" "It is." Then, "When you move, does it bring the pain back?" "It does." You have to deal with a case of "muscle-pain," combined with general debility. If a man, ask, "Do you vomit with it?" "Yes." Then think of a renal calculus. But there is no sickness, so look for some rheumatic thickening. If none, remember a load in the colon is often the cause of lumbago. (The croton-oil "cure" for lumbago in vogue a generation ago was founded on this fact.) Ask after the bowels. If not properly moving, give a cathartic (say Pulv. Jalapæ ℈i). If it is a load in the bowels, you "score one!" If a strumous adolescent, look for lumber abscess, and ask the patient to take a small jump. The jar will produce sharp pain from the shake and pressure on the diseased vertebræ. If a child, ask it to jump down from a stool. It won't! It knows better, if it has spinal disease. Then put it over your knees, separate them so as to draw the lower portion of the trunk away from the upper portion. This relieves the pressure upon the diseased vertebral segments. Ask, "Are you easier now?" The child replies in the affirmative eagerly. Spinal caries, more or less advanced, you may be pretty sure.

When a middle-aged person complains of pain in the back, severe and persisting, and bears the look of pain (Part I. p. 36), you ought to suspect an aneurysm. You say, "Is the pain always there?" "Yes." "Is it worst at bedtime?" (You know that osteal and periosteal pains are always worst at night.) If you get an affirmative answer, then listen carefully over the place for a murmur. Also put the patient flat on the back, and feel for a pulsating tumour. If you are satisfied with the statement of "pain in the back" you will be a little wiser; but if you pursue your inquiries you will probably realise that "he that questioneth much shall learn much." Ask as to "girdle-pains."

When the patient complains of pains under either shoulder-blade, be on the alert. Say, "Put your hand on the pain." It is placed over the inner angle of the scapula, a little upwards and inwards therefrom. This is a characteristic pain, occupying a very localised area. Perhaps the patient will volunteer the remark, "I can cover it

with my thumb." If nothing is volunteered, ask, "Can you cover it with a florin?" "Oh, yes!" the patient gleefully replies, quite delighted with your insight. The "spot of pain" is found with excess of nitrogenised waste in the blood, so ask about the urine: it is either scanty, with lithates, or (if the pulse be hard), copious, pale, and free from deposits. Just take pains to ask the proper question, having felt the pulse carefully. If the latter, you may very safely ask, "Do you get up at nights to pass water?" The patient experiences a sense of waxing confidence in you; if you take care not to spoil the good impression by some untoward question.

But if the patient is a woman, and when told to place her hand over the painful part puts it over the sacrum, be sure about the observation. Ask, "Are you sure the pain is there?" Yes; the patient is quite sure. "Does it run down towards the seat (or back passage)?" "Yes." Now, you have some uterine trouble, or perhaps "ovarian." You go on. "Have you any bearing down?" Yes, she has. "Any pain when your bowels move?" "Yes." "Any pain when you make water?" "Yes." "Have you any discharge?" or "whites," or "weakness." (Mind, women speak vaguely, some using one term, some another; so put first one, then another.)

You have now every reason to believe that there is some pelvic trouble; and whether you proceed to make a physical examination, including a vaginal examination, or wait for some older person to do it, is a matter you must determine for yourself. It is quite safe to say, "There is some trouble about the womb;" and you will usually be right. At least, you have asked enough to demonstrate that you do not overlook the nature of the case in its broad outlines. The case becomes one now too strictly gynæcological for further pursuit here.

Or the patient complains of "constipation," or "diarrhœa." In neither case are you warranted in taking the patient's word "right off." So if constipation is complained of, inquire: "How often do your bowels move?" The answer may be, "Once a week." Whatever it be, make sure that it represents the actual facts. Persons vary immensely with their bowels. Ask if the motions be

large or small: if the latter, probably the patient's food is such as only to form small fæces. If large, an habitual laxative is indicated. One is "costiveness," the other, "constipation." In diarrhœa, always ask, "When your bowels have moved, do you feel relieved?" This is a question of moment. If the alvine discharge be free and copious, or have been free and copious, probably the patient is relieved. But when the answer is, "No; I do not feel relieved;" proceed, "Is the motion small or copious?" The answer is, "It is small." You continue: "And unsatisfactory?" "Yes." Now you may suspect some irritant matter in the bowels, setting up a discharge below itself, and consequently not removing the offending mass. Give a dose of castor oil, which removes the disturbing factor, and the diarrhœa ceases. At other times it is well to ask, "You experience no relief after the bowels have moved?" "No; the feeling is much the same." Now you find you are proceeding with a peculiar case. When there is pressure on the lower bowel, combined with persistent desire to go to stool, you may suspect a mass. Usually it is fæcal; it has been found to be a foreign body in the rectum, or even an ovary or a misplaced uterus. Many a man who is not quite a fool has tripped over a case like this. A recurrent diarrhœa, with small motions, giving no relief, and accompanied by a persistent desire to go to stool, points to a something which can only be settled by a digital examination. But as this is neither agreeable to you nor the patient, see you do not venture upon it, until, by careful well-put questions, you are really certain that you will find something. If you don't—well, you will not produce a good impression. You find something, and remove it; and the patient gets well; and you—well, you will get credit; and you certainly deserve it.

Then there are matters connected with the urinary organs, especially in males, to be considered. And now I wish to impress upon you that, as a young man, it is very necessary for you to be guarded in your inquiries. What has just been said about an examination of the bowel applies even more strongly to the genito-urinary organs. Beyond a natural intelligible delicacy about these organs being seen

and examined, there is the question of the malady having its origin, however remote, in some impure connection. It is difficult for a patient to speak on these subjects to an older man, trebly difficult to do so to a comparative youth. Consequently, take care to know what you are about; and do not ask for an examination until by one or two well-directed questions you have made the case as clear as it can be made without examination; and have impressed the patient that you have a definite aim in making it. To examine a patient *per urethram*, and not to find what you are in search of, is a step in the wrong direction.

In order to enable you to put one or two questions as closely to the point and calculated to elicit the greatest amount of practical information, I have asked Mr. Teevan to revise them for me, as my own surgical knowledge has grown somewhat rusty. Of course, many more questions could be asked; but these are absolutely essential.

A patient, a male, comes to you complaining of discomfort and pain in the pelvis, and some difficulty in making water. You reflect. The three ordinary maladies are: (1) stone in the bladder; (2) enlarged prostate; and (3) stricture of the urethra. This last is all but universally the result of a by-past gonorrhœa; perhaps so long ago as almost to have been forgotten.

Your first question will be, "Is the pain increased by moving about?" Stone, as a practically foreign body, has its symptoms aggravated by movement. You await the answer, "Yes, very much." So far so good. Now for another. "Are you better or worse at nights?" Make sure about your answer; see that it is correctly given. "I am easier at nights." Again stone is indicated; for in stone the rest of bed makes the patient easier; while in enlarged prostate the pain, and discomfort, and desire to get up to make water are increased at night. But there is stricture to be tried for. You ask, "Can you make water all right?" The patient says, "It hurts me very much." You answer, "We will come to that presently. Can you pass your water easily?" Now, in stone the stream is not interfered with, except occasionally, when the stone gets over the outlet and abruptly stops the outflow, while the stream is interfered with

materially in stricture and in enlarged prostrate. "I can make water all right, except it hurts me." You then ask, "Is the pain at the end of the act of making water?" He replies. "Yes; and sometimes the pain is very sharp in the end of my yard." You are by this time pretty certain about the presence of a stone. But one or two questions are still essential. "Do you 'dribble' when you make water? Are there a few drops that come away after you are done?" you ask. "No," is the reply. Now in stricture and in enlarged prostate there is "dribbling." You go on, "Do you ever see any blood in your water?" The patient does; so proceed, "Is it at the last?" In both enlarged prostate and stone the blood comes when the contracted bladder presses the enlarged prostate, or squeezes the stone against the floor of the bladder. You look at the patient; if a country person you ask, "Is the pain worse when you ride on a rough road?" The reply is, "Oh, it murders me to ride in a cart!" or words to the same effect. If a townsman, you put it thus, "Do you ever ride in an omnibus?" He answers briskly, "No, indeed! I've had to give that up long ago." For an adult this is sufficient to justify you in concluding that the presence of stone is so probable that you are quite entitled to ask to be allowed to pass a sound.

If the patient is a boy, it may be more difficult to elicit the requisite information from him, or those with him. Pain in the end of the penis is most significant. Or those with him have noticed him pull the prepuce about more than even boys usually do, and cries when he wants to make water. (Of course, in a boy an enlarged prostrate and a stricture are practically out of the question.) You ask him to "jump off a chair." If he does so without complaining of pain, it is pretty fairly certain that there is no stone.

If it hurts him to do so, be on your guard.

If the patient's answers are to the effect that movement does not make him worse—that he is worse at nights; and that he has difficulty in making water, then proceed for enlarged prostate. "You are sure you are worse at nights?" "Yes; quite sure."

Then, "You have difficulty in making water? How?" "Oh, it does not run freely." You ask then, "How far in front of you can you send your water?" "Bless you, doctor, I can't get it in front of my shoes!" is the answer, or words to the same effect. Remembering that the soft bulging gland blocks the way, and the water only squeezes past the sides with difficulty, you ask, "Does it come in a stream, or in drops?" "Oh, just big drops—drop by drop!" (If there is difficulty in a stricture, there is a stream, but small, with the stream twisted or forked.) You then say, "And you get up often at nights?" "I do that!" is the answer. Then you ask, "Have you pain and discomfort when your bowels move?" "Yes, a good deal," is the answer. The pressure on the contents of the pelvis in the act of emptying the bowels, and so on the prostate, produces the pain. You are pretty certain now about asking the patient to permit a rectal examination, to feel if the gland is enlarged, and in passing a catheter or a bougie.

You will find that the patient often is much worse from a recent drinking-bout, both with an enlarged prostate and a stricture.

Now betwixt the "enlarged prostate" and the "stricture" comes first the great question of age. The "enlarged prostate" is a disease of, say, over fifty; the latter is a disease found in early life. When stricture occurs in a man "up in years," you will usually find on questioning that "the trouble has existed a long time." When the patient is middle-aged or older, it is usually safe to ask, "Have you suffered long?" An affirmative answer helps you very much. If an elderly man, and you have asked these questions, or the patient is a young man, you ask, "You have a desire to pass your water often?" "Yes." "And you experience a good deal of pain?" "Yes." "While you are making water?" "Yes." "Not after?" "No; when I am making it." "And it takes you a long time to make water?" "A terrible long time." "Is the stream small?" "Yes." "Does it twist, or is it forked?" He tells you one or the other, or neither. You ask, "Do you dribble at all?" "Yes, a little," is the reply. The pain during the making

water differentiates the pain of stricture from the pain of stone or enlarged prostate. In stricture it is not the scalding of a gonorrhœa, however. Then, "Do you force a good deal to get the bladder emptied?" The patient does. You are fairly certain now that you have a urethral stricture to deal with, and an examination of the canal with a catheter, or bougie is necessary to tell the nature and the extent of the obstruction.

Perhaps in no series of ailments can well-put, thoughtful questions clear the ground better than in these maladies of the genito-urinary organs. But you can neither put them properly, nor fully appreciate the significance of the answers elicited, if you do not think carefully why certain symptoms should be produced in one case, and be absent in another. For instance, a man comes to you, complaining that he "cannot hold his water." Now, the first idea is, that it is a case of "incontinence," that the bladder cannot hold its contents. But, in reality, the bladder is rather full, than empty: it is full to overflowing. The condition is one of "retention with dribbling." You put the man down on his back, and examine the lower part of the abdomen, and you detect the full bladder. You pass a catheter, and the amount of urine which comes away tells of the nature of the case. Up to fifty years of age the cause is "stricture," after that, "enlarged prostate." Therefore, when a patient complains of "constantly wetting himself," you keep on your guard. When he tells you that "his bladder will not hold his water," it is well to remark, "Perhaps it is too full." This statement will usually provoke an expression of utter incredulity. "How can that be, when my water is constantly coming from me?" Only the sight of water in the utensil can convince him on the matter.

In all disease or disorder of the interior of the body, interrogation as to the subjective sensations of the patient will tell you much of value. But you must know what you are about; why you ask them, and what it is you desire to learn thereby, in order to put them properly, and appreciate the answers.

And now a few words about affections of the limbs, where well-put questions will give useful information.

You know that in morbus coxarius the pain is not felt in the hip, but in the knee most commonly. Therefore, when you see a child limping, you ask, "Where is the pain?" The reply is, "In my knee." You say, "Are you sure of that?" The answer is, "Certain of it." Now examine the hip, as well as the knee; see if it is tender; if so, ask the child to "stamp" the accompanying foot upon the ground. "Stamp the foot down," you reiterate. The child knows better, and will not; or it does, and the pain so produced clears up the diagnosis of osteal mischief, and its locality also.

Or a child is brought to you, the mother telling you, "She has lost the use of one arm." Now such paralysis is exceedingly rare in a young child—not being the remains of "essential paralysis" in infancy. Now always ask, "Will you take hold of my finger?" The child complies. You then say, "Now shake it." The child proceeds to do so, and vigorously too. You watch it intently, and then observe that it has got "chorea," known to the commonalty as "St. Vitus's dance." But the choreic movements may not be very noticeable until the attention given is minute and observant. Never, then, take the word of a patient about the loss of power, without testing it for yourself.

Or, a man comes with "sciatica." Now this is not always so simple a matter as it may seem. The pain of all neuralgia is "gusty;" and though this is not so marked in sciatica as in some other neuralgiæ, it is there. "Is the pain steady and continuous; or it varies—comes and goes?" The answer is, "It is steady." This tells of rheumatic pain in the joint. You then press over the nerve, saying, "Does this hurt you?" Little complaint is made; this strengthens the view of "rheumatism" of the joint. But the answer is, "It comes and goes." So you press over the nerve and ask, "Does this produce pain?" An emphatic "Yes" clears the diagnosis a good deal. "Does the pain shoot down the leg?" you continue. It does. Indeed, often the pain goes down the leg to the foot, as it leaves the sciatic nerves. You then feel down the nerve for tender spots—first at the lower end of the sacrum; then on the trochanter; a

third at the head of the fibula; and a fourth behind the outer ankle. Now ask quietly when you feel about, "Does this hurt?" You can watch the patient's face, if you like, and only put the question when you see him wince; if you are anxious to show off your knowledge, and have self-confidence enough to do it without betraying yourself. When sciatica is of any standing, the motion becomes impaired. Knowing this, you ask, "How long have you had the pain?" "A month," is the response. You follow up, "Can you use that leg properly?" "No," is the answer. You proceed, "Now let us have a look at the leg. Will you put down your trousers?" The leg is found "dwindled," or "pined," as they would say in the north. Now I think you are a good student, and have acquitted yourself well; but you are ambitious, and desire to know whether there is effusion within the sheath of the nerve, or not. When this is the case the limb feels numb, and as if increased in size, as well as being moved with difficulty. Bearing this in mind you follow up, "Is the pain as severe as it has been?" "No," is the answer. "But it is more constant?" "Yes." You proceed, "Does the limb feel numb?" "Yes." Feeling if it is very tender, and finding it more or less sensitive to the touch, you inquire, "Does it feel as if it were swollen; as if it were bigger than it should be?" "Yes;" answers the patient, surprised, and also delighted with your acumen. There is effusion, without much doubt. Now, my young readers, if you can play your hand like this, you will rapidly gain an excellent reputation; and the doctor you are with will probably let you linger a little more in the drawing-room with that good-looking niece of his (that you are getting fond of) than he has hitherto done. Indeed, if you will only go on in this "form," your chances of getting her, and a share of the practice are roseate enough to permit of your indulging in the pleasures of hope; and privately writing to your mother that the girl is very nice, and you would like to stay in that earthly paradise.

Or a patient comes to you complaining of "rheumatism in his knee." He has pain in the joint; so first look at it, or, at least, feel it through the trouser. If you feel

the joint enlarged, ask after an accident, "Have you had any injury to this joint?" "Never any." Then there is either rheumatic or gouty thickening, which is enough for you. Then ask after the pain, "Is it constant?" "Yes, it is." "Is it aggravated by movement?" "Yes; but it is easier and not so stiff after I have been about a bit," is the answer. If not, put your questions accordingly: "Is it quite so stiff after moving about?" Then, "Does it ache when you get warm in bed?" "Yes, it does that!" will be the answer of a countryman, in all probability. Now don't forget some serious affections have been called "rheumatism." Feel for tenderness; ask for shivering; if any, look out for trouble in the bone.

(The "shoulder-tip" pain connected with the liver is usually called rheumatism. When the shoulder is complained of, ask the patient, "Can you hang up your coat?" He will tell you he cannot. Then move the arm, you will find the movement limited by adhesions. This guides you aright.)

But to return to the knee. The answer is, "The pain comes on in shoots, fit to bring me to the ground." Just you ask him to "shut his eyes," and then walk. He feels as if he would fall, and the legs kick out. Then ask him, "Do you feel 'lost' when you get up in the dark?" "Yes," he replies eagerly, feeling you are on the right scent. It is, in all probability, a case of "locomotor ataxy." If the pain is constant, look for rheumatism elsewhere. Thickening of the joints of the hand. Ask, "Have you been subject to rheumatic pains?" You will generally find such a history. Even if it is "rheumatism," look out for "gout" elsewhere. (Many persons dislike the sound of the word "gout," and get quite indignant when they hear it mentioned; so be cautious, and stick to "rheumatism" very carefully.) If you find any thickening of the shins, suspect old syphilis; but be cautious about asking, if it be a gentleman with a family, especially daughters.

Now, there remains "gout in the great toe." When the complaint is made of pain coming on in the night, the case is pretty clear. Or you have to ask, "Did it come on in the night?" See that it is not due to a sprain.

Ask, "Have you sprained it?" Good, intelligent youth, this is a "downy" question. An outbreak of gout in a joint is often set up by a sprain. Just make sure, however, it is not an old bunion.

A final remark. When the patient complains of "pain on movement," either spontaneously, or in response to a question of yours, just insist upon rest as an essential factor in the treatment, and never forget what "shivering" indicates.

Whenever you are inquiring of a patient, or the friends, look about you, see all you can. Ask no question aimlessly. If you note somebody "bursting" to tell you something, ask, "What is it?" Probably it is rubbish, perhaps it is of much value; and when the would-be informant is a woman, sift her story a bit.

When you want an affirmative answer, put the emphasis accordingly. When a negative answer, ask for a negative by the tones of your voice. Mind, too, and don't think me too dogmatic in once more insisting upon this—the patient and friends can only estimate your knowledge by your questions; they can tell nothing about the accuracy of your physical examination. They will eagerly note questions, and "judge of a man by his questions, rather than by his answers." But remember, your answers convey your opinion of the case, and will be awaited with much anxiety. Your questions will have told them to a great extent, whether they can put trust in your answers. Never forget the bystanders are watching you, listening to you; and forming their estimate of you, all the time. In a hospital out-patient-room you may snub an obtrusive questioner; but in private it is scarcely safe to do so, especially if the questioner is speaking to the point. You have to ask questions to gain information, the data upon which, with other matter, you found your opinion; your answers are the measure of what you have gleaned. If pressed by strangers, you are entitled to ask their relation to the sick person, and why they ask the questions they put, before you answer them; but answer accordingly.

CHAPTER V.

ON CONSULTATIONS.

THESE are very important matters in medical life, and I wish to impress this upon the student, especially as such consultations lead, at times, to unpleasantness which is avoidable. Remember first, a patient calls you in to help him to get well, or the friends call you in for that purpose. That is your *raison d'être*. Now, if they are not satisfied with you, they are clearly justified in asking for a consultation with some older person. It does not necessarily involve want of confidence in you—indeed, may be, at times, a delicate way of taking much responsibility off your shoulders. So don't get your back up, or be thin-skinned, or "hoity-toity." They can excuse your further attendance if they like; they, and not you, are really masters of the situation. Never forget that. Then bear in mind this, and don't get wrath with me for drawing your attention to the matter. If you feel quite sure about your diagnosis and treatment, you will be glad of a consultation: it will show you off to advantage. But if your conscience is not at ease, and you know that you have been careless, or do not quite understand the case, then you naturally object to it. This settles the friends in their determination. You have gained nothing by that move.

More especially is this the case where you are a newcomer. Your knowledge may be all right, but how are they to be sure about it?—you are a stranger. But what they do know, and are quite sure about, is that a loved one is ill: one whose life is very valuable to them is sick "nigh unto death," or, at least, they believe so, and very naturally they want to do all that lies in their power.

Possibly they may be rude, rough farming-people, who have little culture, who do not possess the requisite tact necessary to conduct a delicate matter courteously; they are offensive from lack of refinement rather than by deliberate design. Make all allowances for them; try and put yourself in their place, and see what would your line of action be. Above all, keep well in sight, ever and always, they have a perfect right to ask for a consultation if they desire it; and it is weak, puerile, and against your own best interests to oppose their wish. "By all means!" that should be your answer. Let them see you are not afraid of a consultation. You may dislike, may feel the shyness natural to youth in meeting a stranger in such intimacy of thought as a consultation involves. But in a matter of this kind you have to throw your own feelings into the background. Your duty lies plain before you; the path is clear and distinct. So say to the friends, "I will meet any one you choose to call in. Let me know the hour he appoints to be here. and I will hold myself in readiness." Remember, this is also your duty to the consultant. You may be busy, but is he not a busier man than you are? Such propriety of conduct tells in your favour, shows that you do not forget that you are a gentleman, and that you desire to behave like one.

In the meantime think over the case, review the evidence, and criticise your summing up. One thing do not do. Do not set to work to make examination of matters hitherto neglected. You ought to have attended to them before. Don't condemn yourself on the spot by examining the urine, or going thoroughly over the chest for the first time. All that ought to have been done before. It might be permissible to say, "I should like to make a thorough examination of the case, so as to explain to the doctor exactly how it stands now." Or, "I should like to see how the mischief is at present." But do it straightforwardly. Do not prejudice the friends against you by taking pains which contrast with the want of it in your previous examinations.

In the interval you may be arranging the details in your mind so as to be able to lay them out in order to the consultant; if you like consulting your books. You may

thus be all the better enabled to give a reason for the faith that is in you; to explain the how, and why of the conclusions you have arrived at, if they are challenged. And always bear this in mind: you are not to give your interpretation of the phenomena you have observed to the consultant; but the data you have gleaned, themselves—not your opinion of their meaning. That is what the consultant has to do for himself, *viz.*, to interpret them. I insist upon this, because such procedure is not altogether unknown; and is very impertinent. The consultant will ask you, "What do you make of this case?" when you retire after going over the patient.

We will take a case in the country in that class of life where a consultation is apt to "breed mischief." You are attending a man of fifty-five, a grocer and small farmer, who has chronic bronchitis. He was confined to the house when you were first called in. He lies down with much difficulty—indeed, only can do so by much propping up with pillows. He prefers to sit in his arm-chair. He expectorates a good deal; is scant of breath always, but has paroxysms of dyspnœa from time to time. You examine his chest and hear bronchial rales all over. On percussion, you find considerable resonance, especially in front, so that you can scarcely make out any cardiac dulness. There is also a little bit of the base of the left lung dull at the back, and this disturbs you. You feel uneasy about it. You have always seen the backs of the lungs carefully examined in the hospital wards, and you follow what you have seen. You have examined the urine daily for albumen, honestly and carefully. You have given your opinion so: "The case is one of chronic bronchitis and emphysema, with some mischief at the base of the left lung."

The consultant comes; asks you for the outline of the case. You furnish it, probably laying stress upon the dulness at the base. He listens courteously. You then show him into the sick-room, when the patient's wife tells him her version of the illness. The consultant listens attentively, throwing in a question now and again as to the past history of the invalid. He then examines the patient, notices the character of the breathing, feels

the pulse, and then goes steadily over the chest. He lingers about the heart, asks the patient to take a long breath and hold it, while he listens attentively. You begin to feel nervous; he is going to find out something that you have failed to note, and you wish he wouldn't. But, my young friend, he is not sent for to merely endorse what you have said; he is called in to see if anything more can be done, or, "to satisfy the friends." He is doing his duty simply. If he is a kindly gentleman, he will hold the stethoscope on a certain spot, and ask you to listen. You do so. He directs the patient to take a long breath, and hold it. You hear a steady, regular, rhythmic murmur, like a fine saw going through soft wood. You recognise an "aortic systolic" murmur, which you have overlooked or failed to detect, the bronchial rales masking the sound; and somehow you did not think of asking the patient to hold his breath. The consultant asks a question or two, and then turns to the legs. The ankles are swollen; they "pit on pressure;" you had not thought of that either. Then he asks after the water, looks at it, inquires as to the amount; you had not thought of that matter either. The wife answers, "It is less than it was." You feel acutely miserable! He then examines the liver. It is somewhat enlarged. You have never examined that viscus in your daily visits. The wife and another bystander watch the consultant narrowly. You draw his attention to the dulness at the left base; he is not impressed by it. You feel chagrined. In fact, rural practice has blunted the sharpness of his impressions on this matter; so important to him too in his student days. He then asks, very carefully, as to how the patient feels—stronger or weaker. How does he sleep—very disturbed, or not so bad? How is the appetite; is it keeping up, or failing? What amount of milk does he take? What other food? What amount of stimulant? The answers are satisfactory.

He then says, "I think we may retire, and talk the case over." You are shown into another room. You feel very uneasy. What is he going to do about that heart-factor in the case? You are conscious you are in his *hands—at* his mercy if he is an unkindly man. Well, if

he is a brute, or has a grudge against your principal, he may make it "hot"; and if so, I am sorry for you, and think you are hardly used. You have acquitted yourself very fairly on the whole, and your omission was excusable, or very nearly so. If he is a gentleman he will say something of this kind, "You did not hear that aortic murmur before, did you?" You frankly own you did not. He goes on, "Any albumen in the water?"* You reply, "None." He will probably ask you what methods of testing you adopted. You tell him. He asks, "Any sugar?" You never dreamt of that. You say so. He quietly says, "Then take some urine home to-morrow." If it is there, all the worse for the patient. He then asks, "What have you done?" You have given carbonate of ammonia and senega, or other of the mixtures given at page 79 in the "Aids to Rational Therapeutics." He then suggests the addition of ten drops of tincture of digitalis to the dose three times a day—to continue the hot poultices you have already ordered. What will go on is probably something of this kind: "Now we will see Mrs. So and So." She is called in—rather nervous, very anxious. The consultant takes up his parable. "We have gone over the case carefully, and I am sorry to say we find your husband very ill." The wife here breaks down; after a little time he proceeds, "There is a good deal of old lung mischief with bronchitis—of old standing, you know," with a nod. "There is also some mischief in the heart, I find; not very advanced, but it is there. This of course does not improve matters." You feel a little breathless, and are relieved when he oracularly delivers himself, "I think Mr. Youngman has managed the case, so far, very well; and with a little addition to the present medicine, your husband will improve."† "Do you think he will?" asks the wife eagerly, checking her grief for a moment. "Yes; I

* In a case of this kind, the absence of albumen would be very significant indeed.

† That is, if there be a good family history (which is supposed). If this be bad, or the consultant of a timid or desponding temperament, the prognosis given will be much worse.

think he will improve upon his present state, anyhow. You know he has disease about him that will be too much for him after a while. But I think he will rally at present. Mr. Youngman will look well after him." The wife looks up at you gratefully, as much as to say that their suspicions were not well-founded, and that she withdraws any doubts that may have forced their way, or been insidiously instilled into her mind. The olive-branch is held out all round.

Now this is a very satisfactory termination. But such is not the invariable end of a consultation. The consultant may be ill-disposed to your principal; or your conduct may have been faulty, and roused his ire. Or the friends may have noted the move about listening to the heart with the breath stopped, and may want to know more about that.* Consequently some explanation follows; but how the thing may turn it is impossible for me to say. Much, almost all, depends upon the consultant—his tact, his temper, and his good feeling. He is the master of the situation for the time, and that you will realise.

But if the termination I have described is the actual fact, then you will find: (1) Your position is better, and not worse. (2) The friends are satisfied, and this makes your further attendance more pleasant. (3) The patient does improve for a time. Things are pleasant all round; and the friends feel that the money spent has been well expended, and not wasted. Such a consultation is an unalloyed advantage to all.

Would that it were possible to say that such a consultation is invariably found. The selfishness of man may show itself in any one of the three parties, along with a want of consideration for others. And this is too often the fly in the apothecary's pot of ointment!

* This would be very likely in the northern provinces.

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